

10-20

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

33847
REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) DONALD ABRAMS			2a. DATE OF DEATH MONTH DECEMBER DAY 4 YEAR 1984 2b. HOUR 5:00 P M		
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DECEMBER DAY 22 YEAR 1922	6. AGE (IN YEARS LAST BIRTHDAY) 61	IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.		
10. CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 918 SOUTH BELGRADE ROAD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FOOD RECEIVER	12b. KIND OF BUSINESS OR INDUSTRY GIANT FOOD	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS? YES XX NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 918 SOUTH BELGRADE ROAD --20902		
13a. STATE MARYLAND	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING						
14. FATHER'S NAME FIRST WILLIAM MIDDLE ABRAMS LAST ABRAMS			15. MOTHER'S MAIDEN NAME FIRST JENNIE MIDDLE GREENFELD LAST GREENFELD					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES) WW II			16b. SOCIAL SECURITY NO. 218-18-7467			17. INFORMANT HARRIET ABRAMS, 918 SOUTH BELGRADE ROAD SILVER SPRING, MARYLAND		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute bronchopneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b) due to, OR AS A CONSEQUENCE OF squamous cell lung cancer with	3 months
	(c) due to, OR AS A CONSEQUENCE OF bronchiectasis and tracheo-esophageal fistulae	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **a**

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from **Nov 1, 1984** to **Dec 4, 1984**, that (I) (we) last saw the deceased alive on **Sun 12/2, 1984**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Bruce A. Silver, MD	DEGREE	22c. DATE SIGNED 12/5/84
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22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRUCE A. SILVER, M.D.	22e. ADDRESS 106 Irving St., N.W., Wash DC 20010
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23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 12/6/1984	23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN	23d. LOCATION CITY OR TOWN FALLS CHURCH COUNTY VIRGINIA STATE VIRGINIA
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME		25a. DATE REC'D. BY REGISTRAR DEC 11 1984	
23e. ADDRESS 232 CARROLL STREET, N. W., WASHINGTON, D. C.		25b. REGISTRAR'S SIGNATURE John K. ...	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

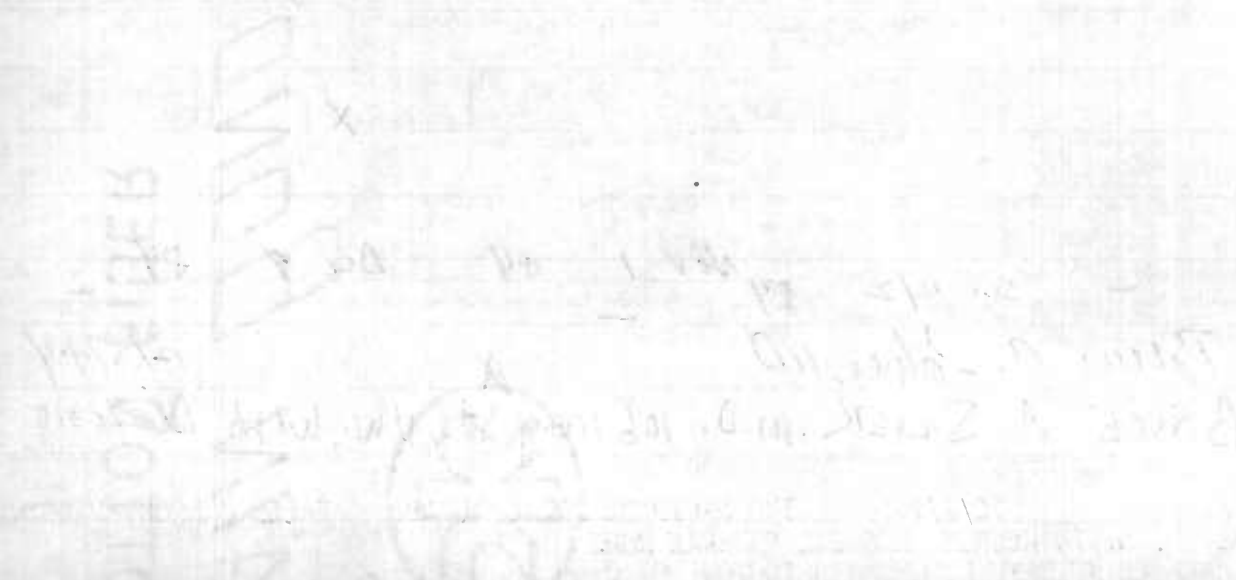
MEDICAL CERTIFICATION

29

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Form 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of completion with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 week
3 months
Annual direct expenditure
Estimated (all) long term with
Investment in research and development



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

33848
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		7c. DATE PRONOUNCED DEAD	
1. DECEASED NAME (TYPE OR PRINT)		2b. DATE KNOWN OF DEATH		3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		7c. DATE PRONOUNCED DEAD	
Dora Hancock Adams		Dec 22 1984		F		W		April 8 1984		94 YRS.				Dec 22 1984	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7d. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH							
Virginia		U.S.A.		WIDOWED		DIVORCED		Montgomery							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Silver Spring		Holly Cross Hosp		Retired Homemaker		Homemaker									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Maryland		Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		12039 Dalewood Drive							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		12039 Dalewood Drive					
James Madison Hancock		Mary White		no		224-10-6539		Iris R. Percy, Silver Spring, Md.		20902					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART I DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a)															
8880 Pulmonary Embolus															
DUE TO, OR AS A CONSEQUENCE OF															
(b) Fracture Rt. Hip															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.															
None															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?											
None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
		0 12 22 1984		Hip collapsed getting out of bed											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION											
		N.H.		Arcola Ave. Sil. Spg. Mont. Md.											
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input type="checkbox"/>		and in my opinion							
death resulted from:		Natural causes <input type="checkbox"/>		Accident <input checked="" type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE											
[Signature]		M.D. [Signature]		Dec 28 1984											
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION									
burial		12/30/84		Hillcrest Cemetery		Louisia, Virginia									
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
NAME WOODWARD FUNERAL HOME, INC.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
ADDRESS BOX 338 LOUISA, VA. 23093		JAN 8 1985		Julia Davidson-Randall											

Handwritten text, mostly illegible due to fading and bleed-through. Some words like "The" and "and" are visible.

RECEIVED

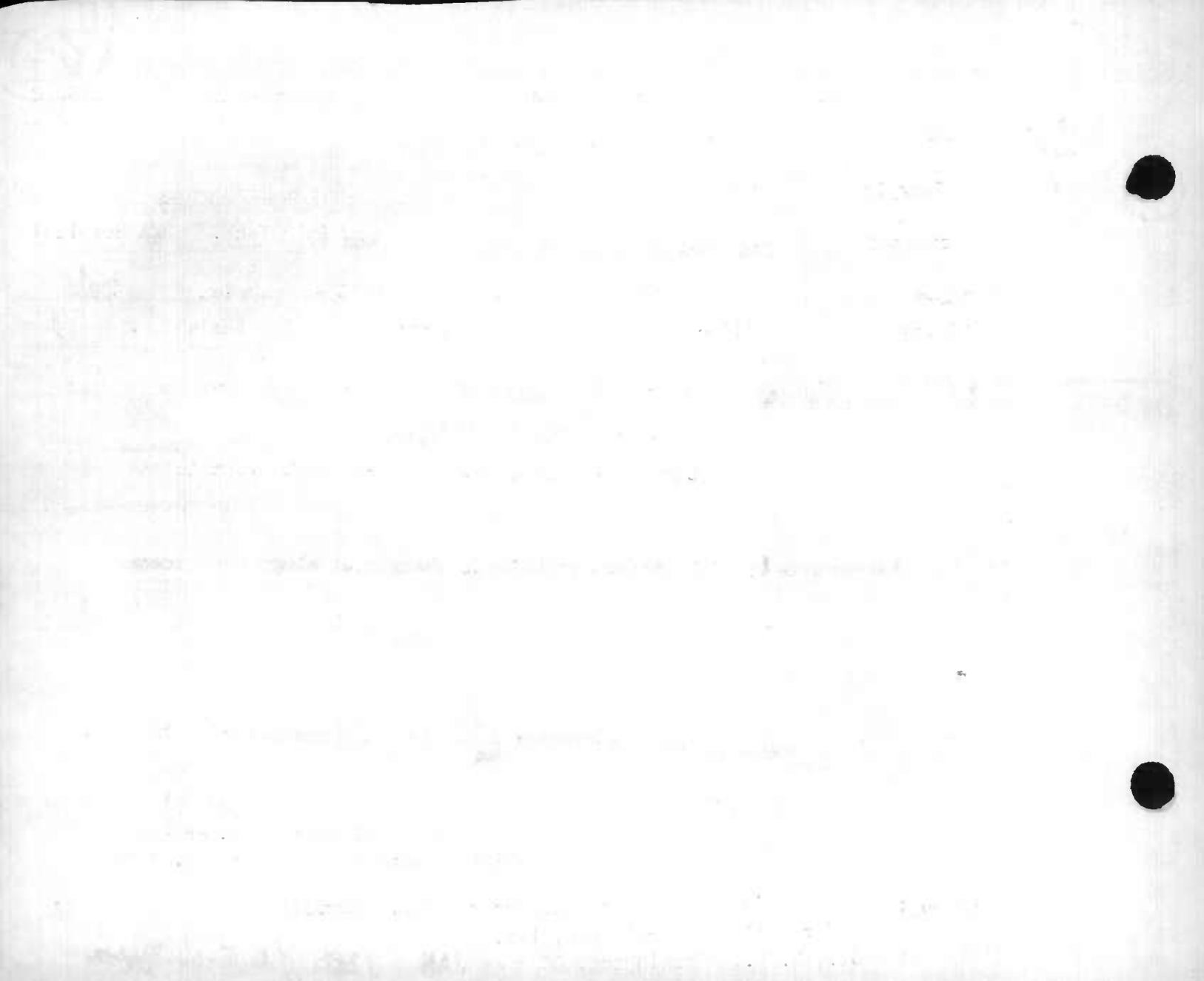


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 4 3 3 8 4 9				REG. NO. 3 3 8 4 9			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Willie Warren Allen				2a. DATE OF DEATH MONTH DAY YEAR December 29, 1984				2b. HOUR 2:55 P.M.	
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR February 18, 1955		6. AGE (IN YEARS LAST BIRTHDAY) 29 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, The Clinical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Med Sply Tech.		12b. KIND OF BUSINESS OR INDUSTRY VA Hospital	
13a. STATE Georgia				13b. CITY OR TOWN Augusta		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 1843 Formosa Dr. 99999-30906	
14. FATHER'S NAME FIRST MIDDLE LAST Linsey Allen				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Seals					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. Vietnam 259-96-3312		17. INFORMANT ADDRESS Mrs. Ora M. Allen, wife Same as patient			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive pneumonia, bilateral DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac failure, both left and right ventricles DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Hepatosplenomegaly with diffuse pathologic changes, etiology undetermined									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 5, 1979, to December 29, 1984, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 29, 1984, and that <input checked="" type="checkbox"/> (our) opinion of death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death.									
22b. SIGNATURE Douglas L. Mallory M.D.						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED Dec. 31/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Douglas L. Mallory						22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, Md. 20205			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 1-3-85		23c. NAME OF CEMETERY OR CREMATORY Peoples Funeral Home		23d. LOCATION CITY OR TOWN COUNTY STATE Augusta GA		
24. FUNERAL DIRECTOR NAME Marshall's Funeral Home, Inc. 4217 9th St., N. W., Washington, DC						25a. DATE REC'D. BY REGISTRAR JAN 7 1985		25b. REGISTRAR'S SIGNATURE John Davidson	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove (detach) pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 3 8 5 0 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JULIUS AMSTERDAM, M.D.						2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 16, 1984				2b. HOUR 11:15 PM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR NOVEMBER 10, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.							
10. CITY OR TOWN OF DEATH POTOMAC		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10821 EDISON ROAD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MEDICAL DOCTOR		12b. KIND OF BUSINESS OR INDUSTRY MEDICINE					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN POTOMAC						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 10821 EDISON ROAD 20854					
4. FATHER'S NAME FIRST MIDDLE LAST PHILLIP AMSTERDAM						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA HEGEL							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		(IF YES, GIVE WAR OR DATES) WWII		16b. SOCIAL SECURITY NO. 162-32-9546		17. INFORMANT ADDRESS LOUISE R. AMSTERDAM, WIFE, SAME AS ITEM #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic carcinoma of prostate DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
9a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from JANUARY 14, 1983 , to Dec 1984 , that (I) (we) lost saw the deceased alive on Dec. 3 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death													
22b. SIGNATURE Richard D. Schubert						DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/17/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD D. SCHUBERT						22e. ADDRESS 1145 19th ST, NW, Washington DC 20036							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 12/17/84		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA VA.							
24. FUNERAL DIRECTOR NAME RICHARD RAPP, INC. WASHINGTON DC 20009						25a. DATE REC'D. BY REGISTRAR DEC 19 1984		25b. REGISTRAR'S SIGNATURE [Signature]					

BP

Figure 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

33851
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BESSIE BURRELL ANDERSON			2a. DATE OF DEATH MONTH DAY YEAR 12 28 84			2b. HOUR MIN. 4 45 P.M.	
3. SEX Female		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 4 3 1900		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PG Mont. MD.	
10. CITY OR TOWN OF DEATH Takoma Park, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic	
13a. STATE Maryland		13b. COUNTY PG		13c. CITY OR TOWN Takoma Park		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Ruben Burrell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown		13e. STREET ADDRESS / ZIP CODE 6709 Poplar Avenue 20912			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 216 46 9343		17. INFORMANT ADDRESS Michael White-nephew-827 Marcy Ave			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiac arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b) **Cachexia**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Metastatic carcinoma breast**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Dehydration

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12 26 19 84 to 12 28 19 84 , that (I) (we) lost Dr. Kijak saw the deceased alive on 12-28-19 84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If not, state (did not) view the body after death.)							
22b. SIGNATURE John Ford MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/29/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN FORD MD		22e. ADDRESS 344 University Blvd W Silver Spring Md 20901					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 2, 1984		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Md	
24. FUNERAL DIRECTOR NAME Stewart Funeral Home-4001 Benning Road, NE				25a. DATE REC'D. BY REGISTRAR JAN 2 1985		25b. REGISTRAR'S SIGNATURE Shaheedon-Randall	

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FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 3 8 5 2
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JAMES Louis ANDERSON			2a. DATE OF DEATH MONTH DAY YEAR 12-16-84		2b. HOUR 3:10 P.M.
3. SEX MALE	4. RACE CAUCASTAN	5. DATE OF BIRTH MONTH DAY YEAR APRIL 19, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH TAKOMA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TYPE SETTER		12b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY	13c. CITY OR TOWN GERMANTOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST JAMES H. ANDERSON			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MYRA BEAUDOIN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 578-20-9204		17. INFORMANT ADDRESS CATHERINE ANDERSON SAME AS 13 WIFE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute monocytic leukemia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 mos					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Jan 1984 , to Dec 1984 , that (I) (we) lost saw the deceased alive on 12-16 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Kai-Yin Yeung MD		DEGREE		22c. DATE SIGNED 12-17-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kai-Yin Yeung MD		22e. ADDRESS 8726 Woodyard Rd # 201 Clinton, Md 20738			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 12/20/84	23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS 500 UNIV. BLVD. W., SILVER SPRING, MD. 20901				25a. DATE REC'D. BY REGISTRAR DEC 19 1984 Jane Davidson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

JAMES EARL RAY - 1-8-21-21 - 1-8-21-21

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH33853
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ANTHONY JOSEPH ANDRIOLE			2a. DATE OF DEATH MONTH DAY YEAR December 16, 1984			2b. HOUR P 10:15 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 20, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, THE CLINICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labor Mediator	
13a. STATE Pennsylvania		13b. CITY OR TOWN Hazleton		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 175 N. Vine Street, 99999	
14. FATHER'S NAME FIRST MIDDLE LAST Ciriaco Andriole			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Deodata Riviello				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 182-16-4639		17. INFORMANT ADDRESS Mrs. Mollie Andriole (wife) same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Diffuse Undifferentiated Lymphoma DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 10 Months
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 31, 1984 to December 16, 1984 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 16, 1984 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.							
22b. SIGNATURE Ann Barber MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/16/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ann BARBER, MD				22e. ADDRESS NATIONAL INSTITUTES OF HEALTH BETHESDA, MARYLAND 20205			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 21, 1984		23c. NAME OF CEMETERY OR CREMATORY Cathedral Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Scranton Lacka. Penna.	
24. FUNERAL DIRECTOR NAME Louis V. Ciuccio 145 Moosic Rd. Old Forge, Pa.				25a. DATE REC'D. BY REGISTRAR DEC 21 1984		25b. REGISTRAR'S SIGNATURE Davidson-Randall	

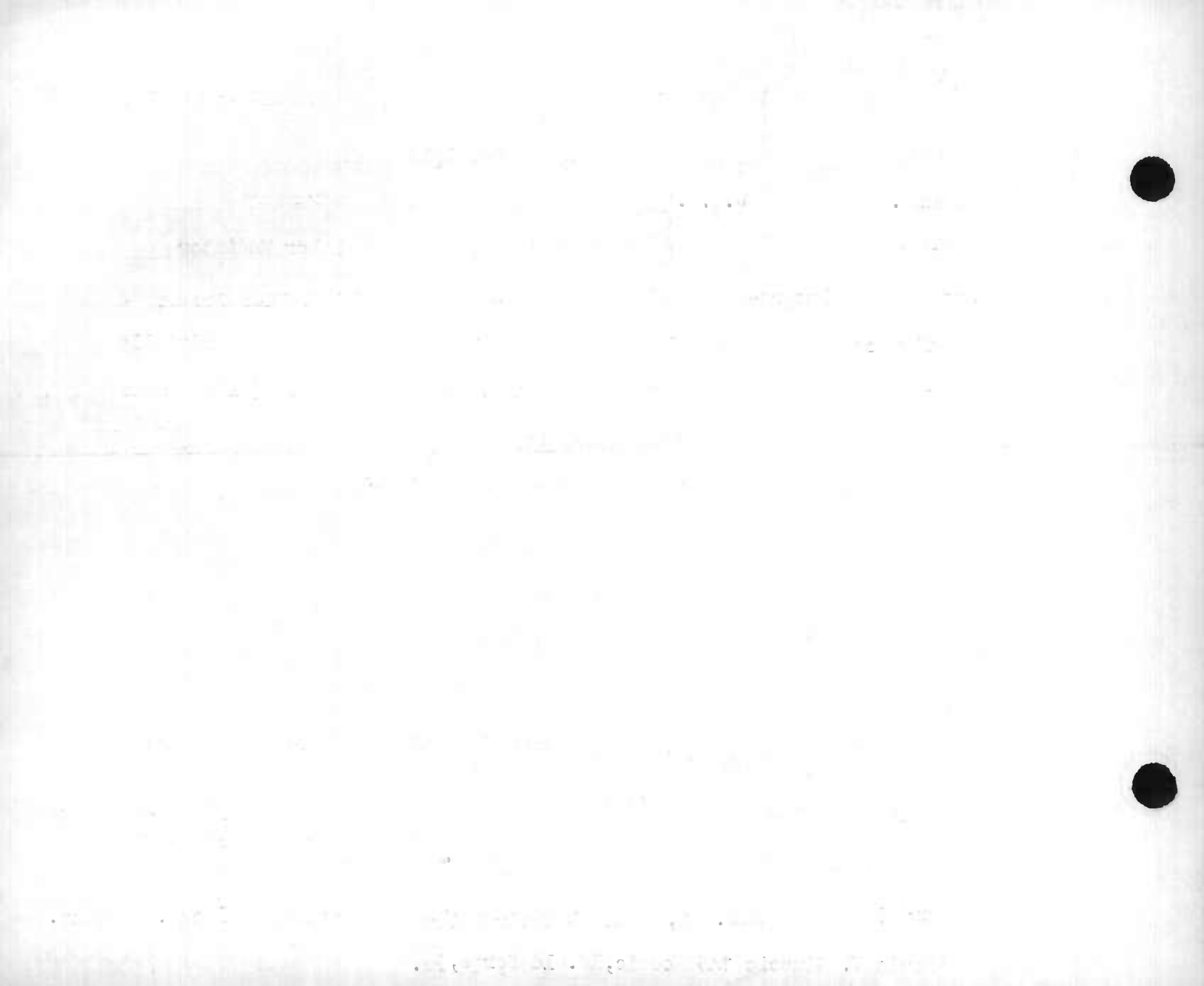
MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be performed.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										33854 REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Minnie G. Apsey						2a. DATE OF DEATH MONTH DAY YEAR Dec 26, 1984		2b. HOUR 1:30 A.M.	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 23, 1899		6 AGE (IN YEARS LAST BIRTHDAY) YRS. 85		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russa		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Randolph Hills Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN Chev Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3706 Thornapple St. 20815			
14 FATHER'S NAME FIRST MIDDLE LAST Max Graef				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Malika Brill							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 098-07-8782		17. INFORMANT ADDRESS Rowena Hoover, Daughter, Same as #13							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic cerebrovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) 20 yrs APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) this hospital attended the deceased from 12/26/84 to 26/2/84 , 19 84 , that (1) (we) last saw the deceased alive on 12/26/84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If two kids did not view the body after death.)											
22b. SIGNATURE Paul J. Voarles				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 26/2/84			
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Paul J. Voarles				22e. ADDRESS 500 Edmonston Rd. Rowland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12-26-84		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory Suitland PG MD		23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME ADDRESS Wilhelm Funeral Home 4308 Suitland Rd Suitland											
DATE REC'D BY REGISTRAR 1/6/85 REGISTRAR'S SIGNATURE J. Davidson-Randall											

MEDICAL CERTIFICATION



April 1914

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33855

1- STATE REGISTRAR				2a. DATE KNOWN OF DEATH				2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)				2c. DATE PRONOUNCED DEAD				2d. HOUR			
Harold C Ashton				12 7 19 84				12 7 19 84			
3. SEX				4. RACE				5. DATE OF BIRTH			
M				Caucasian				3 23 25 59			
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7a. CITIZEN OF WHAT COUNTRY?				7b. BALTIMORE CITY OR COUNTY OF DEATH			
West Virginia				U.S.A.				Montgomery MD			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Bethesda				Suburban Hospital				Superintendent			
13a. STATE				13b. COUNTY				13c. CITY OR TOWN			
Virginia				Fairfax				Falls Church			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16. SOCIAL SECURITY NO.			
Clarence Cloud Ashton				Leona Kettering				236-28-5353			
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				17b. INFORMANT				17c. ADDRESS			
No				Nancy L. Ashton (Wife)				8002 Chanute Place Falls Church, VA			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Cardio pulmonary arrest											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b) acute myocardial infarction											
DUE TO, OR AS A CONSEQUENCE OF											
(c) coronary arteriosclerosis											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
NOT UNDERLYING CONTRIBUTING CAUSE OF DEATH				1:20 PM 12 7 19 84				Single vehicle auto accident			
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION			
WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				Street				Bethesda Montgomery md.			
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from:				Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE			
John Tauber				Deputy				12-7-84			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS				DATE SIGNED			
John Tauber				8218 WISCONSIN AVE				Bethesda md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY			
Burial				12-10-84				National Memorial Park			
23d. LOCATION				23e. COUNTY				23f. STATE			
Falls Church				Fairfax				VA			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Money & King Vienna F.H., Inc.				DEC 13 1984				John Davidson-Rodell			
NAME				25c. REGISTRAR'S SIGNATURE							
171 W. Maple Ave. Vienna, VA 22180											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 3 8 5 6
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Katherine Baker			2a. DATE OF DEATH MONTH DAY YEAR 12-1-84			2b. HOUR 9:30 PM			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 2-10-38		6. AGE (IN YEARS LAST BIRTHDAY) 46 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Montg		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Ashley Dr. 20910	
14. FATHER'S NAME FIRST MIDDLE LAST FRANK Twyman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY A. Wilson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS MARY TWYMAN (mother) 4124 Nevast Ln, Chevy Chase, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) massive cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF (c) Gangrene of both feet 2° to 3° PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b): Loss of cerebral function									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from June 25, 1984, to Dec. 1, 1984, that (I) (we) last saw the deceased alive on Dec. 1, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									22c. DATE SIGNED 12/1/84
22b. SIGNATURE K.S. Cain			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/1/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KWANG SUH KIM			22e. ADDRESS 11119 Rockville Pike #209, Rockville, MD 20852						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-8-84		23c. NAME OF CEMETERY OR CREMATORY Lincoln Park Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montg Md		
24. FUNERAL DIRECTOR NAME George R. Snowden			ADDRESS 246 N. Wash. St. Rockville, Md			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE John Burden	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. No injury, or other traumatic event, the medicolegal examiner must be notified. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				33857 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Alvin M. Balderson</u>				2a. DATE OF DEATH MONTH DAY YEAR <u>12 3 84</u>			
3. SEX <u>Male</u>		4. RACE <u>Cauc</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>FEB 21, 1901</u>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <u>83</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>VIRGINIA</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>MONTGOMERY</u> MD.	
10. CITY OR TOWN OF DEATH <u>TAKOMA PARK</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>WASHINGTON ADVENTIST HOSPITAL</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>BAKERY SALES DEL.</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>CONTINENTAL BAKING CO.</u>	
13a. STATE <u>MARYLAND</u>		13b. CITY OR TOWN <u>PRINCE GEORGES TAKOMA PARK</u>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <u>8009 CARROLL AVENUE 20912</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>GEORGE B. BALDERSON</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>ANNETTE PEED</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>578-07-5590</u>		17. INFORMANT <u>MABLE L. BALDERSON</u>		17. ADDRESS <u>WIFE SAME AS 13</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Cancer of Bladder</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Immunodeficiency</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>							
19a. DATE OF OPERATION <u>NOV 15</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NO</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>11 19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u>INJURY</u>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>1111 Spring St Silver Spring, MD</u>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>1111 Spring St Silver Spring MD</u>		21g. DATE SIGNED <u>12/4/84</u>	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/1</u> , 19 <u>84</u> , to <u>12/3</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>12/2</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				22b. SIGNATURE <u>Robert L. Gorman</u>		22c. DATE SIGNED <u>12/4/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ROBERT L. GORMAN</u>				22e. ADDRESS <u>1111 Spring St Silver Spring, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>12/6/84</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>SUITLAND PRI GEO MD.</u>	
24. FUNERAL DIRECTOR NAME <u>FRANCIS J. COLLINS</u>				25a. DATE REC'D. BY REGISTRAR <u>DEC 10 1984</u>			
25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>				25c. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

DOWN

1958

UNITED STATES DEPARTMENT OF AGRICULTURE

WATER RESOURCES DIVISION

WASHINGTON, D. C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

33858
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) REESE BARKER BALLARD			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 26 1984			2b. HOUR 2:15 a			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR NOVEMBER 24 1915		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GEORGIA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE GEORGIA		13b. COUNTY FLOYD		13c. CITY OR TOWN SILVER CREEK		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE BOX 199, CENTER ROAD 30173	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN WESLEY BALLARD				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. (IF YES, GIVE WAR OR DATES) 1942-1945		16c. SOCIAL SECURITY NO. 256-14-5983		17. INFORMANT ADDRESS GINGER POWELL, P.O. BOX 1423, CARROLLTON, GA 30117			

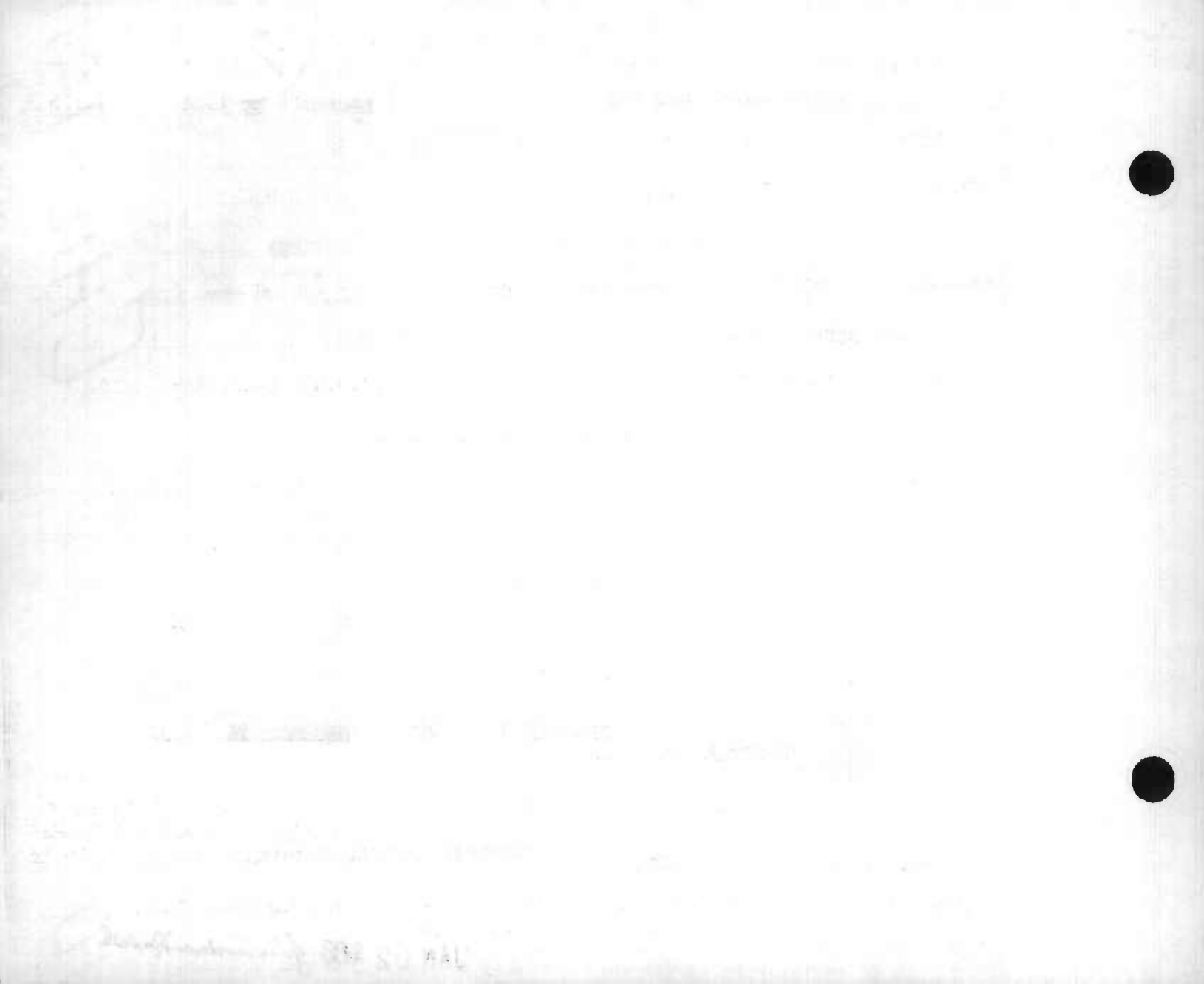
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DISSEMINATED MYCOSIS FUNGOIDES		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) _____			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (c) _____	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 6, 1984 to DECEMBER 26, 1984 , that (I) (we) last saw the deceased alive on DECEMBER 26, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Bruce L Flax				DEGREE MO		22c. DATE SIGNED 27 DEC 84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. L. FLAX, LT. MC, USNR				22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/27/84		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
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24. FUNERAL DIRECTOR NAME MARSHALL FUNERAL HOME		24b. ADDRESS 4217 9th St., N.W. Washington, DC		24c. DATE REC'D. BY REGISTRAR JAN 02 1985		24d. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										33859 REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Ida May Barthlow						2a. DATE OF DEATH MONTH DAY YEAR December 4 '84				2b. HOUR P. 11:45 M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 27 1890		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Mont. Maryland MD.					
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 307 Westside Drive #203				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 307 Westside Dr. #203			
14. FATHER'S NAME FIRST MIDDLE LAST William Elliott Kemp				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Linda Matilda Lampert							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT (Husband) Leroy W. Barthlow		ADDRESS 307 Westside Dr. #203 Gaithersburg, Md. 20878					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Lymphocytic Leukemia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Decubitus Ulcers, Congestive Heart Failure, skin cancer, etc.											
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from October 19, 84, to Washington, 19, that (I) (we) lost saw the deceased alive on 12/4/84 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Susan Withrow MD				DEGREE MD				22c. DATE SIGNED 12/6/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Susan Withrow				22e. ADDRESS 15 E Den Park Dr, Gaithersburg, Md. 20877							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/8/84		23c. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Gaithersburg Montg. Md.			
24. FUNERAL DIRECTOR NAME Gartner Sandison F.H. Gaithersburg, Md. 20877				25a. DATE REC'D. BY REGISTRAR DEC 11 1984		25. REGISTRAR'S SIGNATURE Julia Davidson					

BP

BP_____

DHMH . 17

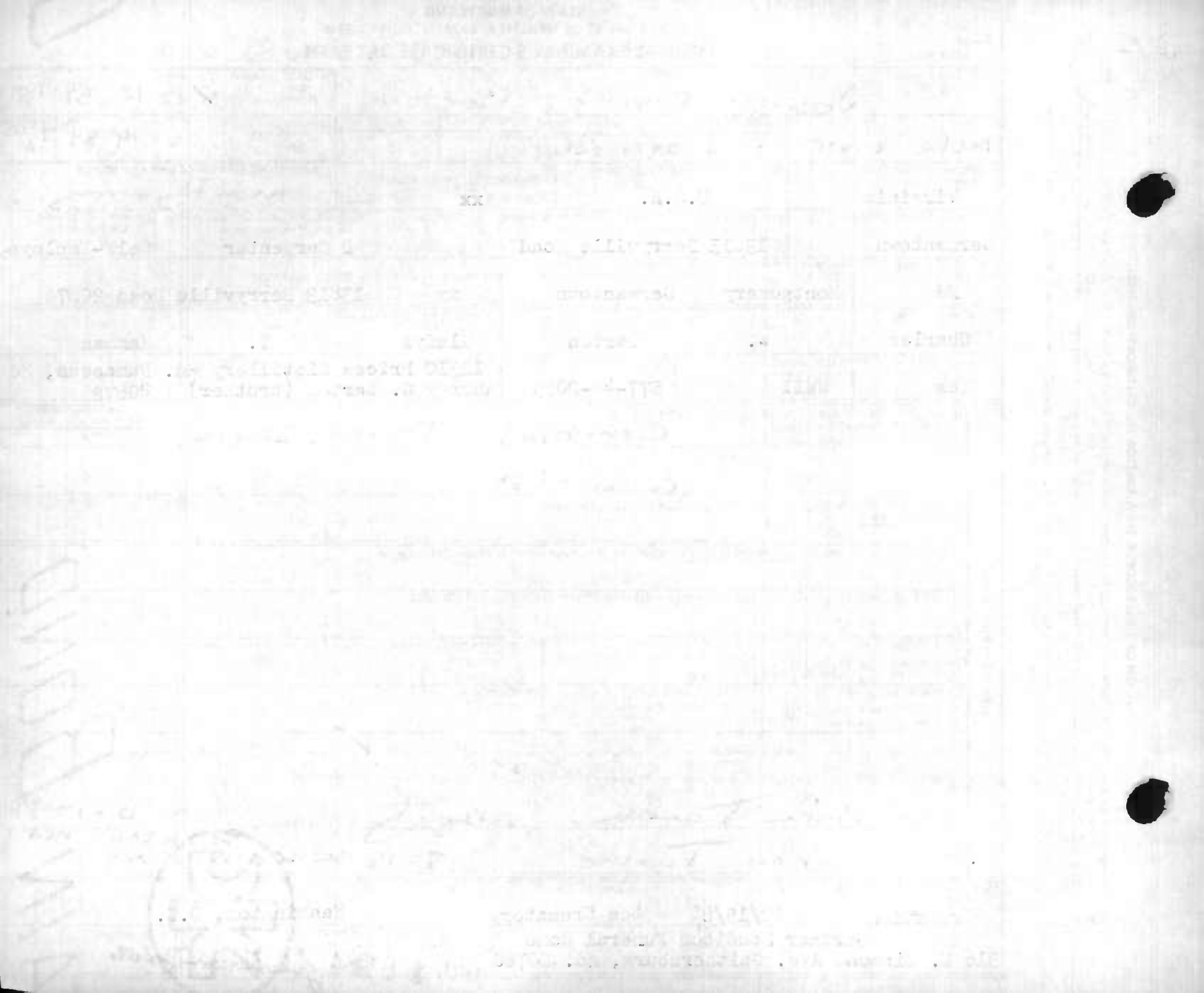
(VR A15 ME (5))

20M 4/B2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

366

FOR 1- STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH								73360	
1. DECEASED NAME (TYPE OR PRINT) Joseph Charles Barton				2a. DATE KNOWN OF ESTI- MATED 12 12 1984				2b. HOUR 7:00 A			
3. SEX Male		4. RACE White		5. DAY OF BIRTH MONTH DAY YEAR 1 4 28		6. AGE (IN YEARS) LAST BIRTHDAY 60 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN. YES XX NO		IF UNDER 24 HRS. NO	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Germantown				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 13813 Berryville Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) D Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Self-Employed	
13a. STATE Md		13b. COUNTY Montgomery		13c. CITY OR TOWN Germantown		13d. INSIDE CITY LIMITS? YES XX NO		13e. STREET ADDRESS 13813 Berryville Road 20874			
14. FATHER'S NAME FIRST MIDDLE LAST Charles W. Barton				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gladys I. Hamman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WWII				16b. SOCIAL SECURITY NO. 577-40-2059		17. INFORMANT 12310 Prices Distillery Rd. Damascus, Md Aubrey G. Barton (brother)				ADDRESS 20872	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Trauma, Severe DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) Gun shot DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John Tauber				TITLE (SPECIFY) M.D. Deputy				DATE SIGNED 12-14-84 MEDICAL EXAMINER Bethesda Md			
EXAMINER'S NAME (TYPE OR PRINT) John Tauber				ADDRESS 8218 Wisconsin Ave							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/15/84		23c. NAME OF CEMETERY OR CREMATORY Lee Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.			
24. FUNERAL DIRECTOR NAME Gartner Sandison Funeral Home 316 E. Diamond Ave. Gaithersburg, Md. 20760						25a. DATE REC'D. BY REGISTRAR DEC 14 1984		25b. REGISTRAR'S SIGNATURE Lidia Davidson-Randall			



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										33861 REG. NO.			
1. FOR STATE REGISTRAR					2a. DATE OF DEATH					2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Pearl Beckwith					2a. DATE OF DEATH MONTH DAY YEAR 12-23-84					2b. HOUR 1:30 PM			
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 10-12-02		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Circle Manor				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Practical nurse			12b. KIND OF BUSINESS OR INDUSTRY Private duty				
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 10231 Carroll Place 20895				
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Dwyer					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Lila Page								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214206409		17. INFORMANT Leanne M. Lloyd			ADDRESS Same as above						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years.													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from after 3:00 PM, 1984 to after 11:23 PM, 1984, that I (we) last saw the deceased alive on after 11:23 PM, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.													
22b. SIGNATURE Regina Ferguson, MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1/22/85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Regina Ferguson, MD					22e. ADDRESS 3720 Fennell Ave, Hyattsville, Md 20785								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/27/84		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION STREET CITY OR TOWN COUNTY STATE Brentwood Md						
24. FUNERAL DIRECTOR NAME Donaldson Funeral Home										DATE REC'D. BY REGISTRAR 3.1.85		REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				33862 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 12-26-84 2:15 PM			
I. DECEASED NAME (TYPE OR PRINT) LAST MIDDLE FIRST BEIRAM, FATEMEH				3. SEX F. RACE C. 1			
5. DATE OF BIRTH MONTH DAY YEAR MAY 28, 1921				6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS. 11 M. 5 D.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IRAN				7b. CITIZEN OF WHAT COUNTRY? IRAN			
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH POTOMAC, Mont. MD.			
10. CITY OR TOWN OF DEATH POTOMAC				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6 LAUREL LEAF CT.			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE				12b. KIND OF BUSINESS OR INDUSTRY -			
13a. STATE MARYLAND				13b. COUNTY MONT.			
13c. CITY OR TOWN POTOMAC				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS 6 LAUREL LEAF CT.				20854			
14. FATHER'S NAME FIRST MIDDLE LAST MAHMOUD BEIRAM.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SOE HRA 4/A			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No -				16b. SOCIAL SECURITY NO. NONE			
17. INFORMANT ADDRESS SON-BAHRAM BEIRAMEE SAME AS #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LIREMIA SECONDARY TO CANCER DUE TO, OR AS A CONSEQUENCE OF (b) OF UTERUS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Approx. 6 months							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION NONE HERE				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CERVICAL BIOPSY IN IRAN			
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (I) (this hospital) attended the deceased from DEC 23, 19 84, to DEC 26, 19 84, that (I) (we) lost saw the deceased alive on DEC. 25th, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE H.A. Barakat MD				22c. DATE SIGNED 12-26-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H.A. BARAKAT MD				22e. ADDRESS 9440 MARLBORO PIKE Suite 330 (HASSAN A. BARAKAT) LIPPER MARLBORO MD 20772			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE DEC 27, 1984			
23c. NAME OF CEMETERY OR CREMATORY ISLAMIC GARDENS				23d. LOCATION CITY OR TOWN COUNTY STATE FALLS CHURCH, VA			
24. FUNERAL DIRECTOR NAME GONZALEZ				25a. DATE REC'D. BY REGISTRAR 31 1984			
25b. REGISTRAR'S SIGNATURE Julia Davidson							

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

33863
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) David Elwin Bestpitch			2a. DATE OF DEATH MONTH DAY YEAR 12 16 84			2b. HOUR 6:16P M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JUNE 30. 1931		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BUILDING SUPERINTENDENT		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD				13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN LUTHIAN	
14. FATHER'S NAME FIRST MIDDLE LAST ELWIN W. BESTPITCH				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MINNIE WHIDDEN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 213-756-5310		17. INFORMANT ADDRESS WILLIAM D. BESTPITCH, RICHMOND VA	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ESOPHAGO PLEURAL CUTANEOUS FISTULA MONTHS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) Gradually into esophagus & empyema MONTHS		MONTHS TO YEARS (1 1/2)
DUE TO, OR AS A CONSEQUENCE OF (c) Squamous carcinoma		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 1(a):
Coronary artery disease with arrhythmia

19a. DATE OF OPERATION (12-3-84)		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CHANGE OF LARGE ARTERIES		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/3 19 84 , to 12/16 19 84 , that (I) (we) last saw the deceased alive on 12/15 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Kenneth Cruze MD.				DEGREE MD.		22c. DATE SIGNED 12/17/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KENNETH CRUZE				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE Dec. 18. 1984		23c. NAME OF CEMETERY OR CREMATORY Earl Lunsford Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood MD	
24. FUNERAL DIRECTOR NAME Takoma Funeral Home, J. C. Walters				25. DATE REC'D. BY REGISTRAR DEC 24 1984			
26. REGISTRAR'S SIGNATURE J. Davidson-Randall							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

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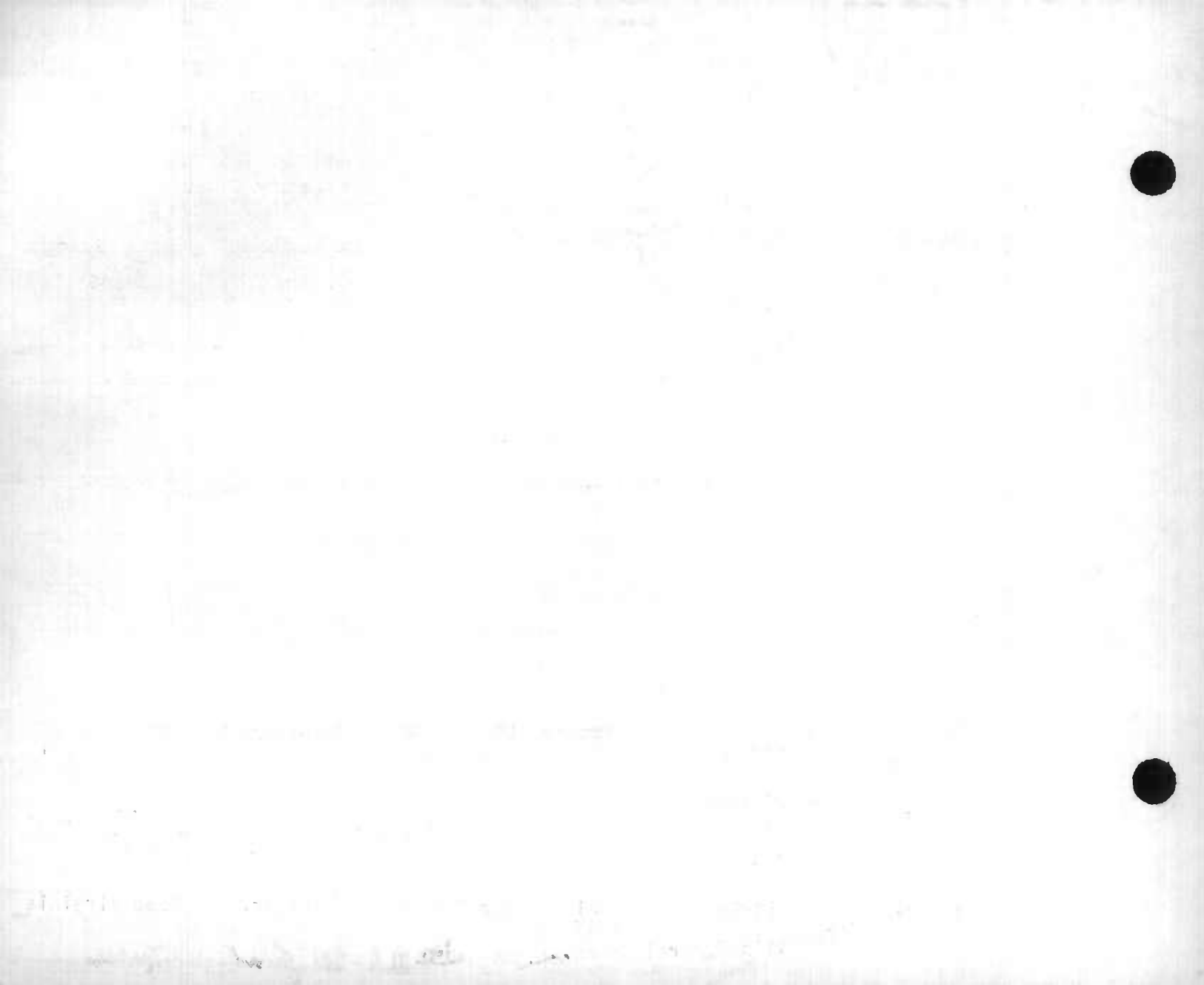
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1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 33864

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Gary Edward Birchfield			2a. DATE OF DEATH MONTH DAY YEAR December 4, 1984		2b. HOUR 10:55P
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 31, 1961		6. AGE (IN YEARS LAST BIRTHDAY) 23 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, The Clinical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supply Clerk	12b. KIND OF BUSINESS OR INDUSTRY Coal Mining	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE W. Virginia		13b. COUNTY	13c. CITY OR TOWN Isaban	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS & ZIP CODE P. O. Box 7 24846
14. FATHER'S NAME FIRST MIDDLE LAST James Allen Birchfield		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Jean Stacy			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 232-13-4864		17. INFORMANT ADDRESS Mr. James Birchfield, father, same as patient	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hodgkins Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>October 19</u> , 19 <u>84</u> to <u>December 4</u> , 19 <u>84</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>December 4</u> , 19 <u>84</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Sanford Markowitz</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED Dec. 5, 1984
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sanford Markowitz, MD		22e. ADDRESS Clinical Center, National Institutes of Health, Bethesda, Maryland 20205			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal	23b. DATE 12-7-84	23c. NAME OF CEMETERY OR CREMATORY Fanning Funeral Home		23d. LOCATION CITY OR TOWN COUNTY STATE laeger, West Virginia	
24. FUNERAL DIRECTOR NAME Marsha		ADDRESS 11's Funeral Home Wash. DC		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

33865
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Forrest L Bishop			2a. DATE OF DEATH MONTH DAY YEAR 12 8 84		2b. HOUR 5 A M
3. SEX male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 23 1920		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Jet Pilot	12b. KIND OF BUSINESS OR INDUSTRY US Air Force	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST John M. Bishop			15. MOTHER'S MAIDEN NAME MIDDLE LAST Olive M. Bond		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. Retired USAF 578-03-3356		17. INFORMANT ADDRESS Josephine M. Herbert - companion - (same as 13e)	

18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardial infarction</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Chronic obstructive pulmonary disease</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 84 to 12/8/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Lewis H. Dixon</u> DEGREE				22c. DATE SIGNED 12/8/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis H. Dixon, MD				22e. ADDRESS 831 Univ. Blvd., E. Silver Spring, Md.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Dec. 11, 1984	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia
24. FUNERAL DIRECTOR Name Rinaldi Funeral Home		25a. DATE REC'D. BY REGISTRAR DEC 12 1984	
25b. ADDRESS Silver Spring, Md.		25c. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.

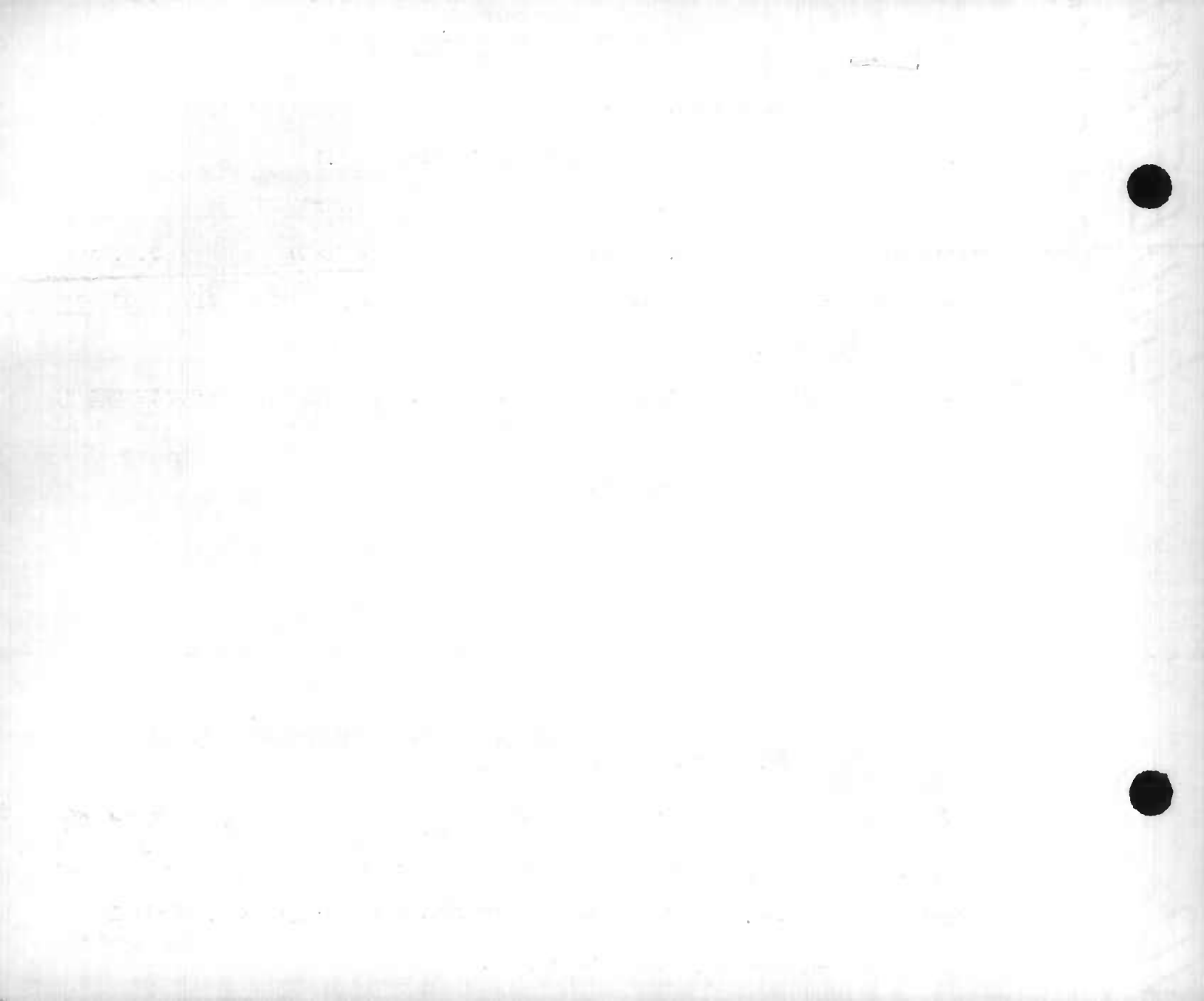
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 specifies any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 3 8 6 6 REG. NO.			
1. FOR STATE REGISTRAR						1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST MELVIN CHARLES BISSONETTE		2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 9 1984		2b. HOUR 4:57 a.m.	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR DECEMBER 14 1932		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SOUTH DAKOTA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.							
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY					
13a. STATE RHODE ISLAND		13b. COUNTY NEWPORT		13c. CITY OR TOWN MIDDLETOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7 ADMIRALTY DRIVE 02840					
14. FATHER'S NAME FIRST MIDDLE LAST FRED BISSONETTE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALICE REDWING									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1951-1971		17. INFORMANT ADDRESS MARGARET E. BISSONETTE, 7 ADMIRALTY DRIVE, MIDDLETOWN, RI 02840							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NO! WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from OCTOBER 31 1984, to DECEMBER 9 1984, that (I) (we) last saw the deceased alive on DECEMBER 9 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.													
22b. SIGNATURE R. L. NEMEC				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 10 Dec 84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. L. NEMEC, LT, MC, USNR				22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 14, 1984		23c. NAME OF CEMETERY OR CREMATORY Newport Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Middletown, Rhode Island							
24. FUNERAL DIRECTOR NAME ADDRESS Capitol Funeral Service, Falls Church, Va.				25a. DATE REC'D. BY REGISTRAR DEC 14 1984		25b. REGISTRAR'S SIGNATURE Rendell							

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH33867
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ROBERT CROCKETT BLACKINGTON			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 6 1984		2b. HOUR 3:40 P
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR MARCH 13 1935		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) FLORIDA	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA	NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED	12b. KIND OF BUSINESS OR INDUSTRY U.S.M.C.	
11a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE VIRGINIA		13b. COUNTY MATHEWS	13c. CITY OR TOWN MATHEWS	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE BOX 471 KINGSTON PARISH 23104
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT C. BLACKINGTON			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH WARD		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1957-1978	17. INFORMANT ADDRESS NANCY C. BLACKINGTON, BOX 471, KINGSTON		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA OF THE LUNG COMPLICATED BY DUE TO, OR AS A CONSEQUENCE OF (b) MASSIVE PULMONARY HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 3 , 19 84 , to DECEMBER 6 , 19 84 , that (I) (we) last saw the deceased alive on DECEMBER 6 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.					
22b. PHYSICIAN'S NAME (TYPE OR PRINT) W. A. DELACEY, LT, MC, USNR		22c. DATE SIGNED 12/6/84		22d. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814	
23a. BURIAL, CREMATION, REMOVAL CREMATION		23b. DATE Dec. 8, 1984	23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA, VIRGINIA
24. FUNERAL DIRECTOR NAME Ives Pearson Funeral Homes		ADDRESS Arlington, VA 22201		25. SIGNATURE OF FUNERAL DIRECTOR Ives Pearson	

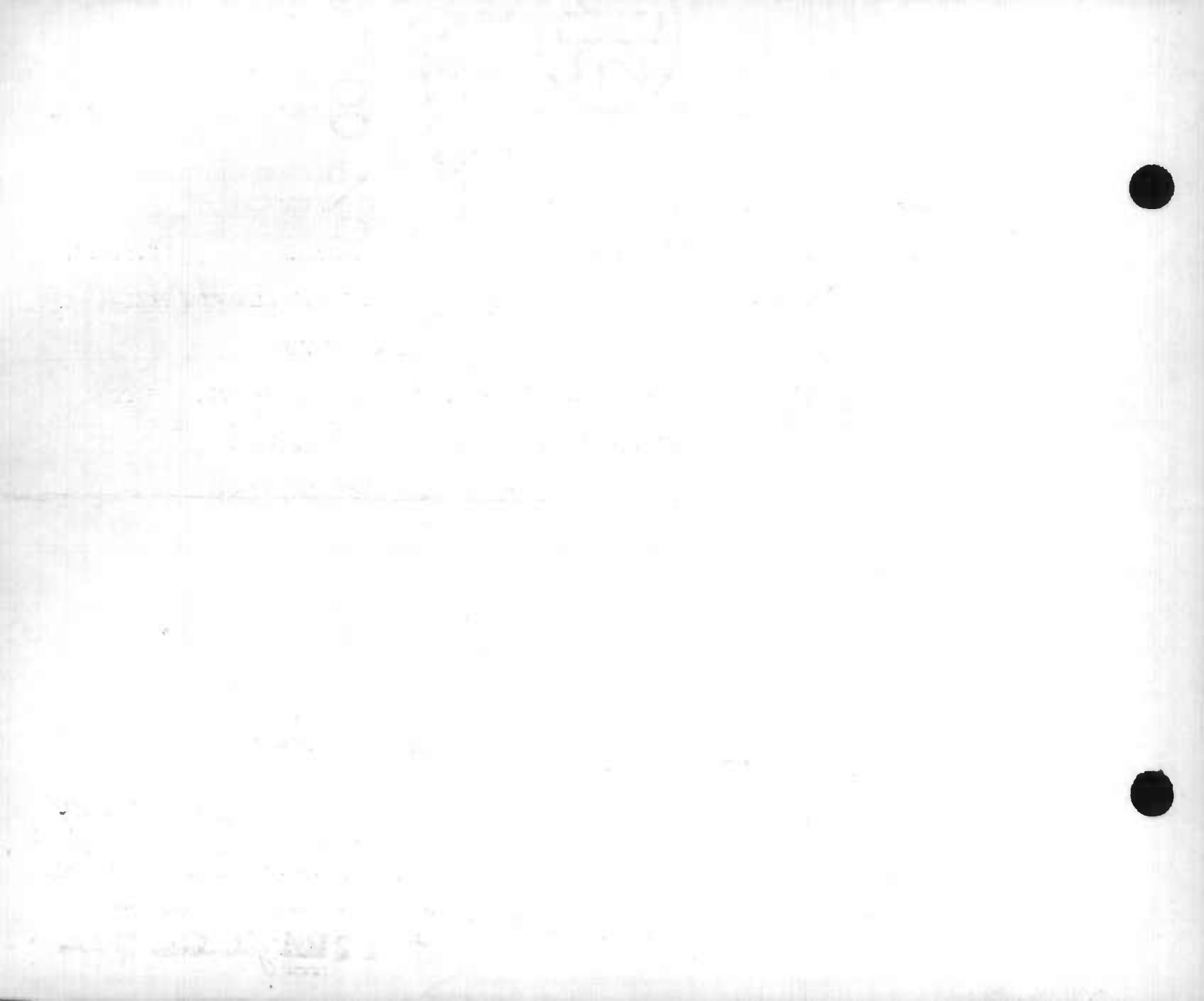
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified at once.

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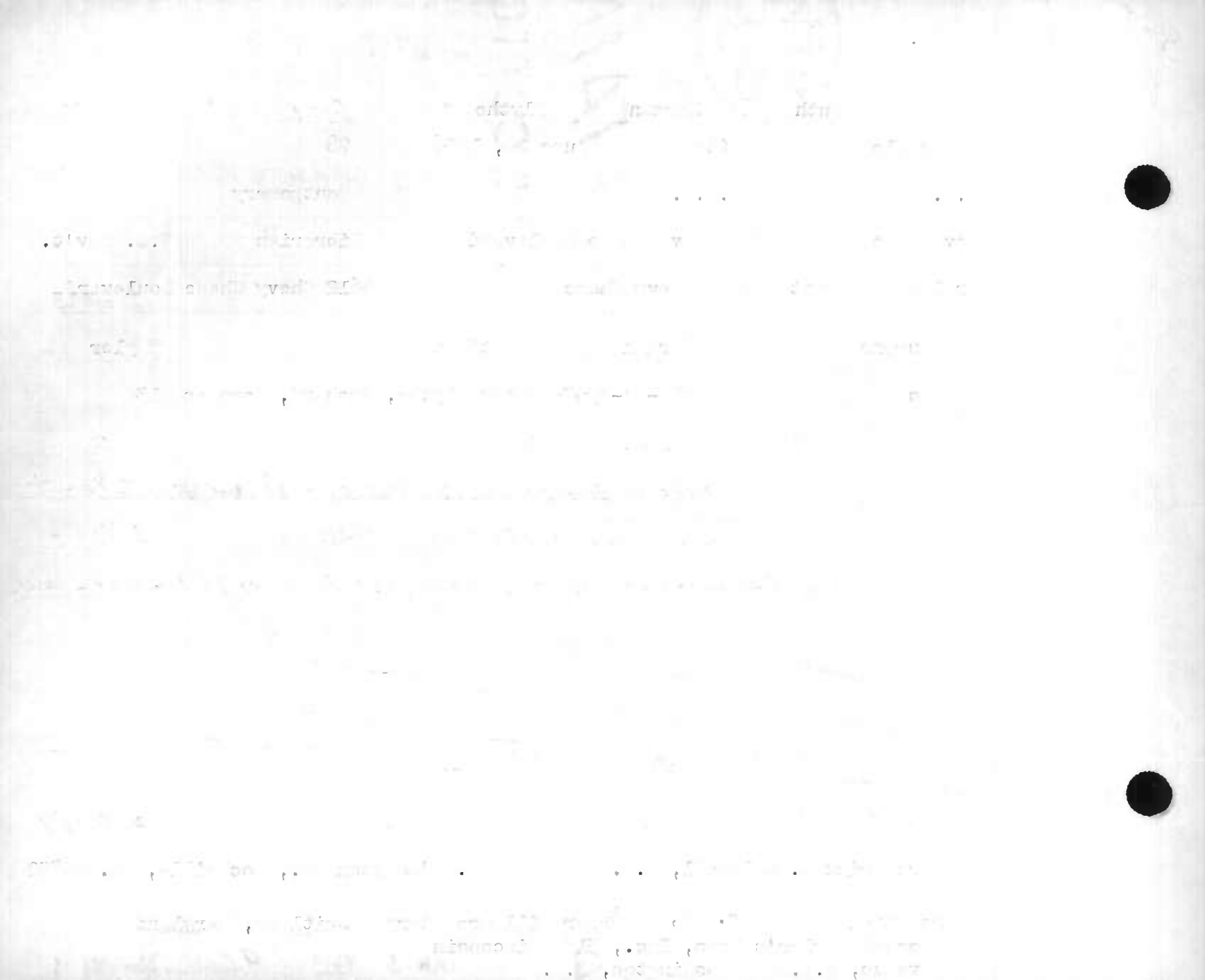
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 33868			
1. FOR STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ruth Kernan Blythe							2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 23, 1984			2b. HOUR 230 P.M.			
3 SEX Female		4. RACE White		5. DATE OF BIRTH June 20, 1906			6. AGE (IN YEARS LAST BIRTHDAY) 78		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.						
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 4612 Chevy Chase Boulevard					12a. USUAL OCCUPATION (TYPE, DUTY, OR CLASS OF WORKING LIFE) Librarian		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		14. STREET ADDRESS, ZIP CODE 4612 Chevy Chase Boulevard 20815				
14. FATHER'S NAME FIRST MIDDLE LAST Eugene Kernan				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Matilda Taylor									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 220-44-6543M		17. INFORMANT ADDRESS John Blythe, Husband, Same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ISCHEMIC HEART DISEASE SEVERE, & CHRONIC</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <u>AND SEVERE COPD & PULM FIBROSIS</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>0</u> <u>2 YRS +</u> <u>2 YRS +</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>SEVERE RHEUMATOID ARTHRITIS & SJOGREN'S SYNDROME; CEREBRAL VASC INSUF.</u>													
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>1965</u> , 19____, to <u>present</u> , 19____, that (I) (we) lost saw the deceased alive on <u>12/4/84</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Frederick S. Caldwell</u>				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/24/84</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frederick S. Caldwell, M.D.				22e. ADDRESS 50 W. Edmonston Dr., Rockville, Md. 20852									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Dec. 27, 1984		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland					
24. FUNERAL DIRECTOR NAME Gawler's Sons, Inc., Address Avenue, N.W. Washington, D.C.				25a. DATE REC'D. BY REGISTRAR JAN 3 1985				25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>					

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 JOM 2/80
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 3 8 6 9
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Mina Amind Montgomery Bogges		Dec. 28, 1984		9:45 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	7. IF UNDER 1 YEAR	
Female	White	Nov. 17, 1904	80	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH		
TX	U.S.A.	NEVER MARRIED	Montgomery MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION	12a. USUAL OCCUPATION	12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring	319 Stonington Rd.	Insurance Agent	Insurance		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Texas		San Antonio	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	435 Northridge Dr. 78209	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			
Charles Clay Montgomery	Catherine Long	No (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			
16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS			
458-24-6644	Albert Bogges	319 Stonington Rd. Sil. Sp. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Respiratory arrest</u>					<u>minutes</u>
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
(b) <u>Adrenocortical tumor + electrolyte abn - met</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(c) <u>Gynecological cancer (stromal cell) 7 yrs.</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED			
<input type="checkbox"/>	HOUR A.M. MONTH DAY YEAR	(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
OR CONTRIBUTING CAUSE OF DEATH	P.M.	19			
21d. INJURY OCCURRED	21e. PLACE OF INJURY	21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11/26</u> , 19 <u>84</u> , to <u>12/28</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>12/27</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN		MEDICAL DIRECTOR	STAFF PHYSICIAN
<u>Richard P. Delaney</u>	M.D.	<input checked="" type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
22d. PHYSICIAN'S NAME	22e. ADDRESS				
Richard P. Delaney, M.D.	4323 Havard Street, Silver Spring, Md. 20906.				
23a. BURIAL, CREMATION, REMOVAL	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
Burial	Jan. 4, 1985	Sunset Mem. Park	San Antonio, Texas		
24. FUNERAL DIRECTOR	25a. DATE REC'D. BY REGISTRAR				
NAME	B.C. JAN 3 1985				
Joseph Gawler's sons	5130 Wisc. Ave N.W. Wash. D.C.				

REGISTRAR'S SIGNATURE
John Davidson

Blank lined paper with two binder holes on the right side.

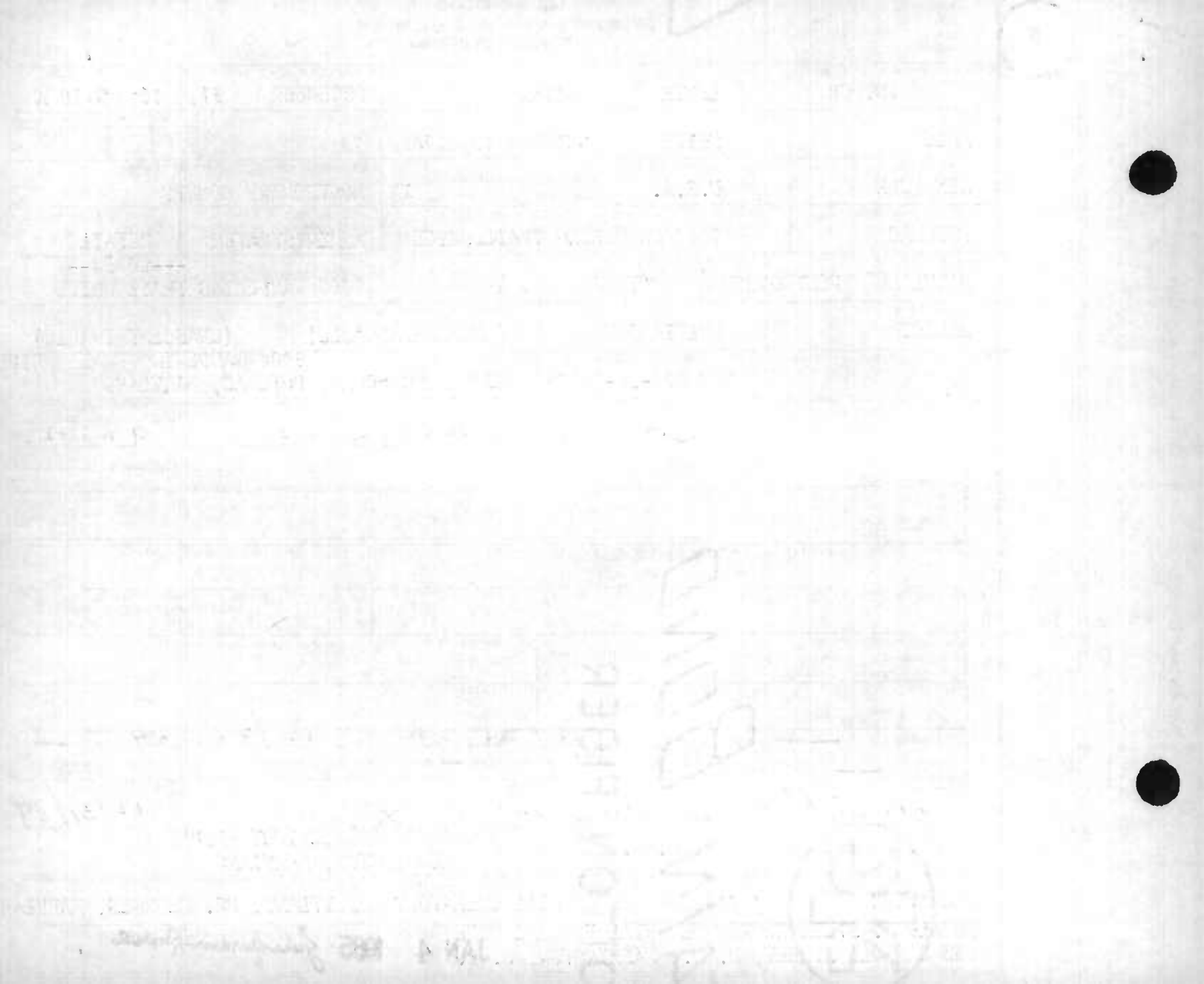
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				33870 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ISIDOR LEWIS BOLTAN				2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 31, 1984		2b. HOUR 5:10 A.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 13, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH POTOMAC		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9004 WANDERING TRAIL DRIVE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ADMINISTRATOR		12b. KIND OF BUSINESS OR INDUSTRY RETAIL	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN MARYLAND MONTGOMERY POTOMAC				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9004 WANDERING TRAIL DRIVE ---20854---	
14. FATHER'S NAME FIRST MIDDLE LAST BAURACH BOLTIANSKY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (UNASCERTAINABLE) (UNASCERTAINABLE)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 094-26-3931A		17. INFORMANT 9004 WANDERING TRAIL DRIVE NORMA ZUCKERMAN, POTOMAC, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) COLON CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 12/24 19 84 , to 12/31 19 84 , that (I) (we) saw the deceased alive on 12/25 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
23a. SIGNATURE Daniel Rosenthal				DEGREE MD		23c. DATE SIGNED 12/31/84	
23b. PHYSICIAN'S NAME (TYPE OR PRINT) DR. DANIEL ROSENBLUM, M. D.				23d. ADDRESS 10400 CONNECTICUT AVENUE KENSINGTON, MARYLAND			
23e. BURIAL, CREMATION, REMOVAL CREMATION		23f. DATE 1/2/1985		23g. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY		23h. LOCATION SUITLAND, PR. GEORGES, MARYLAND	
24. FUNERAL DIRECTOR STEIN HEBREW MEMORIAL FUNERAL HOME NAME ADDRESS 232 CARROLL STREET, N. W., WASHINGTON, D.				25. DATE REC'D BY REG. BUREAU JAN 4 1985 REGISTRAR'S SIGNATURE <i>[Signature]</i>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										33872 REG. NO.	
1. FOR STATE REGISTRAR					2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)					FIRST MIDDLE LAST		12 6 84		5 30 A M		
3. SEX					4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		
FEMALE					WHITE		OCT 17 1903		181 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
WASH. D. C.					U.S.A.				MONTGOMERY MD		
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
TAKOMA PARK					WASHINGTON ADVENTIST HOSP.					ASSAULT LINE RADIO SOUNDS	
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		
Maryland					P.G. Co.		Laurel		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					16. STREET ADDRESS / ZIP CODE	
FIRST MIDDLE LAST					FIRST MIDDLE LAST					1017 8th. St.	
Frederick					Rose					Roberta Payne	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT				
No.					218-20-1542		Walter E. Boswell				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a)					Cardiac Respiratory Arrest						
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					(b) Aspiration Pneumonia, Sepsis						
DUE TO, OR AS A CONSEQUENCE OF											
(c) Rt Hemisphere Stroke, Diabetic Arteriosclerosis											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
					HOUR A.M. MONTH DAY YEAR						
					P.M. 19						
21d. INJURY OCCURRED					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK								STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4-13-1984 to 12-6-1984, that (I) (we) last saw the deceased alive on 12-5-1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE					DEGREE					22c. DATE SIGNED	
Tony P. Kannarkat					MD					12/6/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS						
TONY P. KANNARKAT, MD					8201 16th St S.S. MD 20910						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION	
Burial					12/8/84		Ivy Hill Cemetery			Laurel, P.G. Co. Md.	
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR					25b. REGISTRAR'S SIGNATURE	
FLECK FUNERAL HOME, INC.					DEC 12 1984					P. Davidson-Randall	
7601 Sandy Spring Rd. Laurel, Md. 20707											



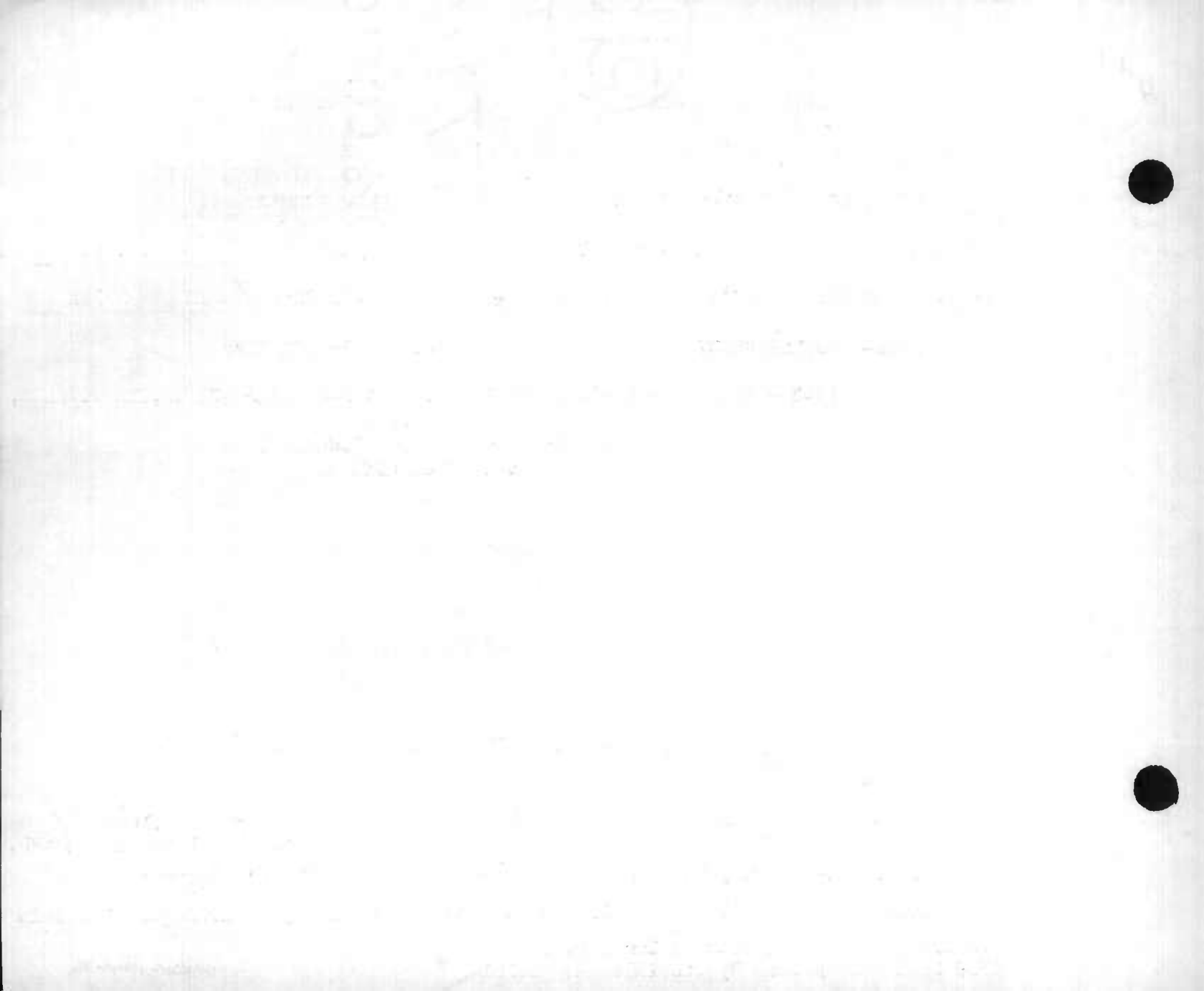
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 3 8 7 3 REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT EARLE BRADY						2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 12 1984		2b. HOUR P M 6:00 P M	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR MARCH 24 1922		6. AGE (IN YEARS LAST BIRTHDAY) 62		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		7. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, DC		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Jeweler		12b. KIND OF BUSINESS OR INDUSTRY Self Employed			
13a. STATE MARYLAND		13b. COUNTY PRINCE GEO'S		13c. CITY OR TOWN HYATTSVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5823 32nd AVENUE 20782			
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE MONROE BRADY						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RUTH ELIZABETH TAPP					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1942 - 1963		17. INFORMANT GLORIA F. BRADY		ADDRESS 5823 32nd AVENUE, HYATTSVILLE, MD 20782					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SQUAMOUS CELL CARCINOMA COMPLICATED BY DUE TO, OR AS A CONSEQUENCE OF RESPIRATORY FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 10 , 19 84 to DECEMBER 12 , 19 84 , that (I) (we) last saw the deceased alive on DECEMBER 12 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22a. SIGNATURE <i>W. A. Delacey</i>		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/17/84					
22a. PHYSICIAN'S NAME (TYPE OR PRINT) W. A. DELACEY, LT. MC, USNR		22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/17/84		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Fort Myer Arlington Virginia					
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, MD 20781						25a. DATE REC'D. BY REGISTRAR DEC 17 1984		25b. REGISTRAR'S SIGNATURE <i>Davidson-Randall</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 33874	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ethel Clare Brainard						2a. DATE OF DEATH MONTH DAY YEAR December 6, 1984			7b. HOUR 6 A.M.		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCT 20 1888		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MO.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 415 SILVER SPRING AVE # 506				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY			12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN SILVER SPRING						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE SAME AS 11 20910			
14. FATHER'S NAME FIRST MIDDLE LAST JASPER SITTON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADA RUSSELL							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 498-07-6794		17. INFORMANT ADDRESS VIRGINIA BRAINARD SAME AS 13 e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOVASCULAR COLLAPSE DUE TO, OR AS A CONSEQUENCE OF (b) CARDIAC ARREST-ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) ROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:10 CITROMA BRAIN SYNDROME											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (in this hospital) attended the deceased from <u>DEC 1</u> , 19 <u>73</u> , to <u>DEC 6</u> , 19 <u>84</u> , that (I) (we) lost <u>we</u> the deceased alive on <u>DEC 1</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Joseph Solinas for DR. DRAPER MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/06/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH M. SOLINAS MD						22e. ADDRESS 9801 GEORGIA AVE. S.S. Md. 20902					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE DEC, 6, 1984			23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREM.			23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA VA		
24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS 500 U.B.W., SILVER SPRING, MD						25a. DATE REC'D. BY REGISTRAR DEC 10 1984			25b. REGISTRAR'S SIGNATURE Julia Davidson-Rendall		

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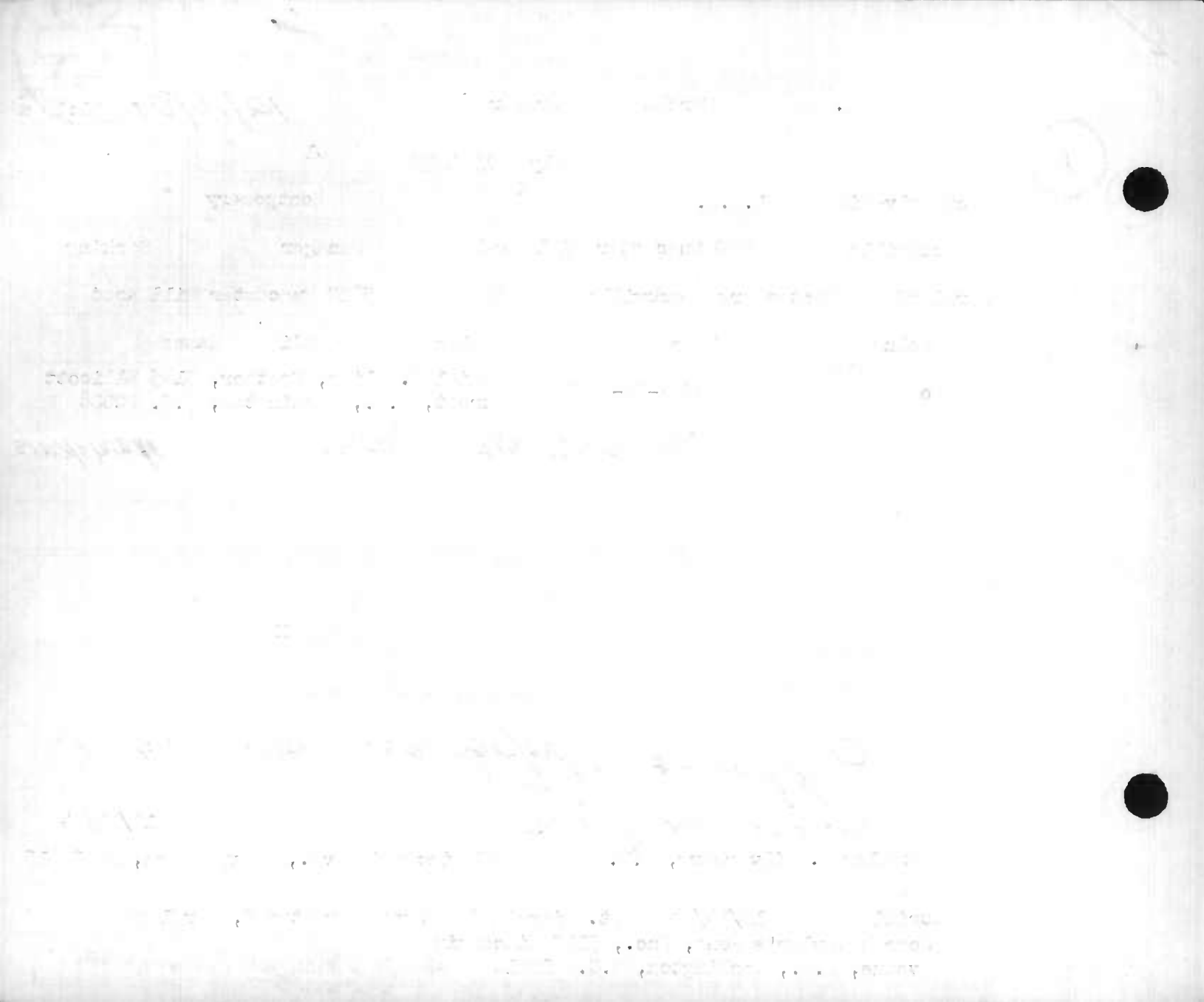
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										33875 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) M. Marsha Brewer						2a. DATE OF DEATH MONTH DAY YEAR 12/10/84		2b. HOUR am 11:15 A			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 17 1923		6. AGE (IN YEARS LAST BIRTHDAY) 61		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 5020 Muncaster Mill Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager		12b. KIND OF BUSINESS OR INDUSTRY Banking			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5020 Muncaster Mill Road 20851			
14. FATHER'S NAME FIRST MIDDLE LAST John Elias				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Sadi Hanna							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 577-26-0323		17. INFORMANT NAME ADDRESS Daniel J. Elias, Brother, 3145 Ellicott Street, N.W., Washington, D.C. 20008					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 11/26 19 84 , to 12/10 19 84 , that (I) (we) lost saw the deceased alive on 11/26 19 84 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Stanley M. Silverberg				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/11/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stanley M. Silverberg, M.D.				22e. ADDRESS 5530 Wisconsin Ave., Chevy Chase, MD 20815							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/14/84		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Maryland					
24. FUNERAL HOME NAME ADDRESS Joseph Gawler's Sons, Inc., 5130 Wisconsin Avenue, N.W., Washington, D.C. 20016				25a. DATE REC'D. BY REGISTRAR DEC 17 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, then any injury, or other traumatic event, the medical examiner must investigate.

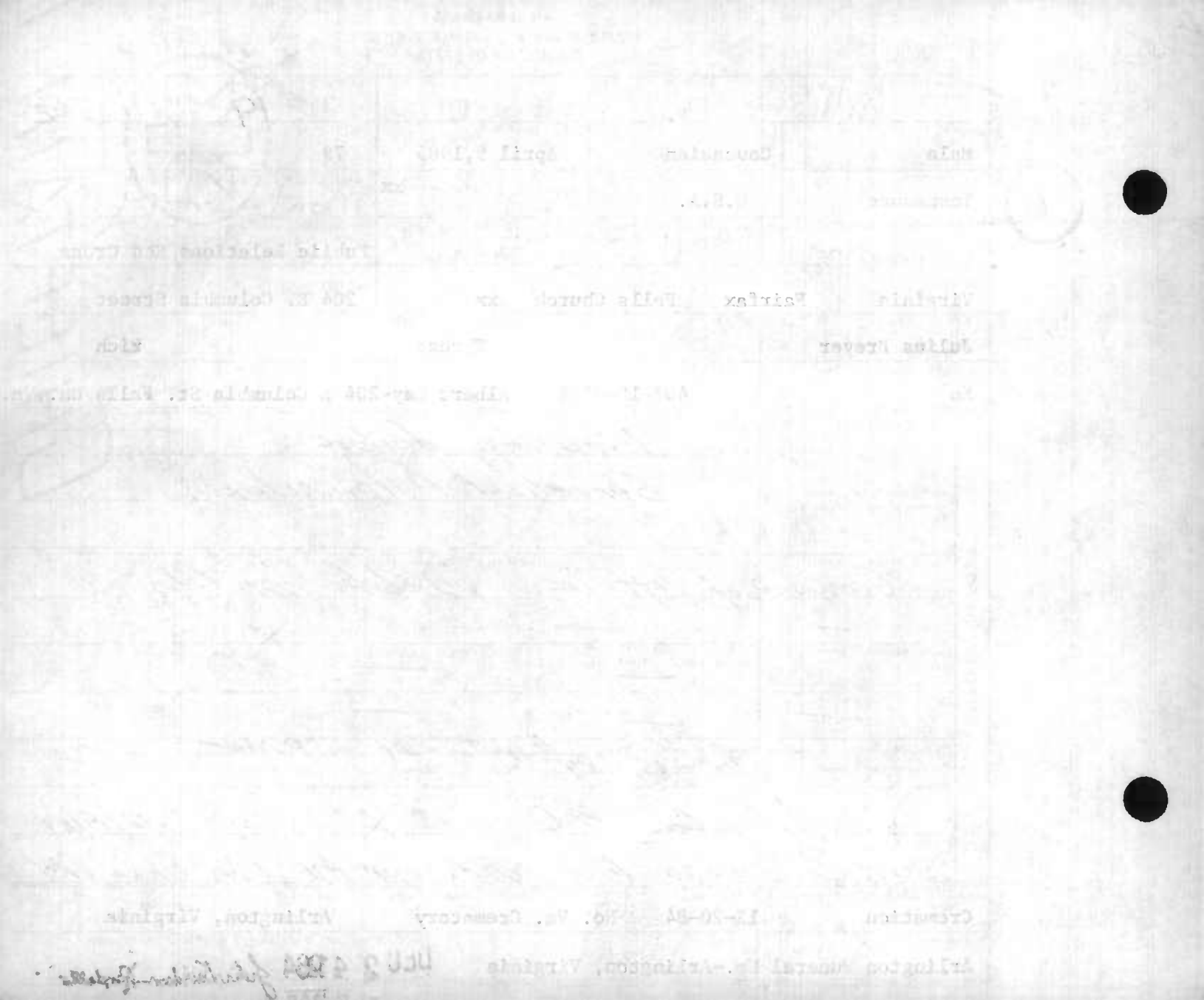
FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

33876

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>William R. Breyer</u>		2a. DATE OF DEATH MONTH DAY YEAR <u>12-19-1984</u>		2b. HOUR <u>7:55</u> AM
3. SEX <u>Male</u>	4. RACE <u>Caucasian</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>April 9, 1905</u>	6. AGE (IN YEARS LAST BIRTHDAY) <u>79</u> YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Tennessee</u>	8b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.	
10. CITY OR TOWN OF DEATH <u>Silver Spring</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NO SUCH FACILITY, GIVE STREET ADDRESS) <u>Calvary Nursing Center</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Public Relations</u>	12b. KIND OF BUSINESS OR INDUSTRY <u>Red Cross</u>
13a. USUAL RESIDENCE IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION 13a. STATE <u>Virginia</u>	13b. COUNTY <u>Falls Church</u>	13c. CITY OR TOWN <u>Falls Church</u>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <u>204 E. Columbia Street</u>
14. FATHER'S NAME FIRST MIDDLE LAST <u>Julius Breyer</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Thresa Rich</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>408-10-0086</u>	17. INFORMANT ADDRESS <u>Albert Kay-204 E Columbia St. Falls Ch., Va.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Gangrene of left leg. Diabetes mellitus</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b)				
19a. DATE OF OPERATION <u>—</u>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NO WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>—</u>	21f. LOCATION STREET <u>—</u>	CITY OR TOWN <u>—</u>	COUNTY <u>—</u> STATE <u>—</u>
22a. I certify that (I) (this hospital) attended the deceased from <u>August</u> , 19 <u>81</u> , to <u>present</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>Dec. 15</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
27b. SIGNATURE <u>John B. Umbau</u>	DEGREE <u>MD</u>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	27c. DATE SIGNED <u>12/19/84</u>	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>John B. Umbau MD</u>		27e. ADDRESS <u>8805 Conn. Ave. Chevy Chase, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>	23b. DATE <u>12-20-84</u>	23c. NAME OF CEMETERY OR CREMATORY <u>No. Va. Crematory</u>	23d. LOCATION CITY OR TOWN COUNTY STATE <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR NAME ADDRESS <u>Arlington Funeral Hm.-Arlington, Virginia</u>		25a. DATE REC'D. BY REGISTRAR <u>DEC 24 1984</u>		
		25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				33877 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Carrie F. Briggs				2a. DATE OF DEATH MONTH DAY YEAR 12 / 18/84			
3. SEX Female				4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR June 14, 1908	
6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Caroline County		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Caroline County MD.	
10. CITY OR TOWN OF DEATH Denton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Caroline Nursing Home, Inc.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Canning House		12b. KIND OF BUSINESS OR INDUSTRY Canning	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Caroline 13c. CITY OR TOWN Denton				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Rt. 404 21629	
14. FATHER'S NAME FIRST MIDDLE LAST Alonzo Jones				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Cephas			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 098-16-1966A		17. INFORMANT ADDRESS Annie L. Green, Rt. 1, Box 7, Rhodesdale, Md. 21659			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Death - Prob Arrhythmia DUE TO, OR AS A CONSEQUENCE OF (b) AS CVD DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: C.H.F. Mitral Insufficiency							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. ALIEN PSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/11/84 to 12/18/84, that (II) (we) post mortem the deceased on 12-18-84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did not view the body after death.							
22b. SIGNATURE DEGREE David S. Smith MD				ATTENDING PHYSICIAN MEDICAL <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/18/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David S. Smith MD				22e. ADDRESS Caroline Health Services, Denton, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 22, 1984		23c. NAME OF CEMETERY OR CREMATORY Washington Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hurlock, , Dorchester, Maryland	
24. FUNERAL DIRECTOR NAME Thompson - Hawkins F.H.				25a. DATE RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 24 1984 J. L. Davidson			

not me

2040 J. Neurosci., July 26, 2006 • 26(30):2034–2044

Figure 1

8-20 1-31 10-11 2

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 3 8 7 8
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTH DAY YEAR	
FLORENCE F. BRINTON		12 23 84		10 ⁵⁵ P. M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
F	Caucasian	4 10 97	87 YRS	MONTHS	DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Penna.	U.S.A.		Mont. County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring MD	ALTHEA WOODLAND N.H.	ART Editor	ART		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
N/A	N/A	WASHINGTON DC	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	2931 CATHEDRAL AVE., N.W. 20008	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			
BINNEY	BRINTON	NO			
16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
468-20-5205		MISS EMILY HAMMOND		3945 CONNECTICUT AVE WASH. D.C. 20008	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <u>GENERALIZED ARTERIOSCLEROSIS</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>SENILITY, PERIPHERAL VASCULAR DISEASE</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 13</u> 19 <u>84</u> to <u>Dec 23</u> 19 <u>84</u> , that we (we) last saw the deceased alive on <u>Dec 23</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
<u>Bernard A. Fitzgerald</u>				12-23-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS				
BERNARD A. FITZGERALD	217 UNIVERSITY BLVD E. SILVER SPRING, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE	23e. DATE REC'D. BY REGISTRAR	
CREMATION	12/24/84	METROPOLITAN CREMATORY	ALEXANDRIA VIRGINIA	20901	
24. FUNERAL DIRECTOR NAME	24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		
FRANCIS J. COLLINS	500 UNIV. BLVD., W., SILVER SPRING, MD. 20901		DEC 31 1984		

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A small handwritten mark or character, possibly a page number or a section indicator.

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Handwritten text, possibly a line of a list or a paragraph, appearing in the lower section of the page.

Handwritten text, possibly a line of a list or a paragraph, appearing at the bottom of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

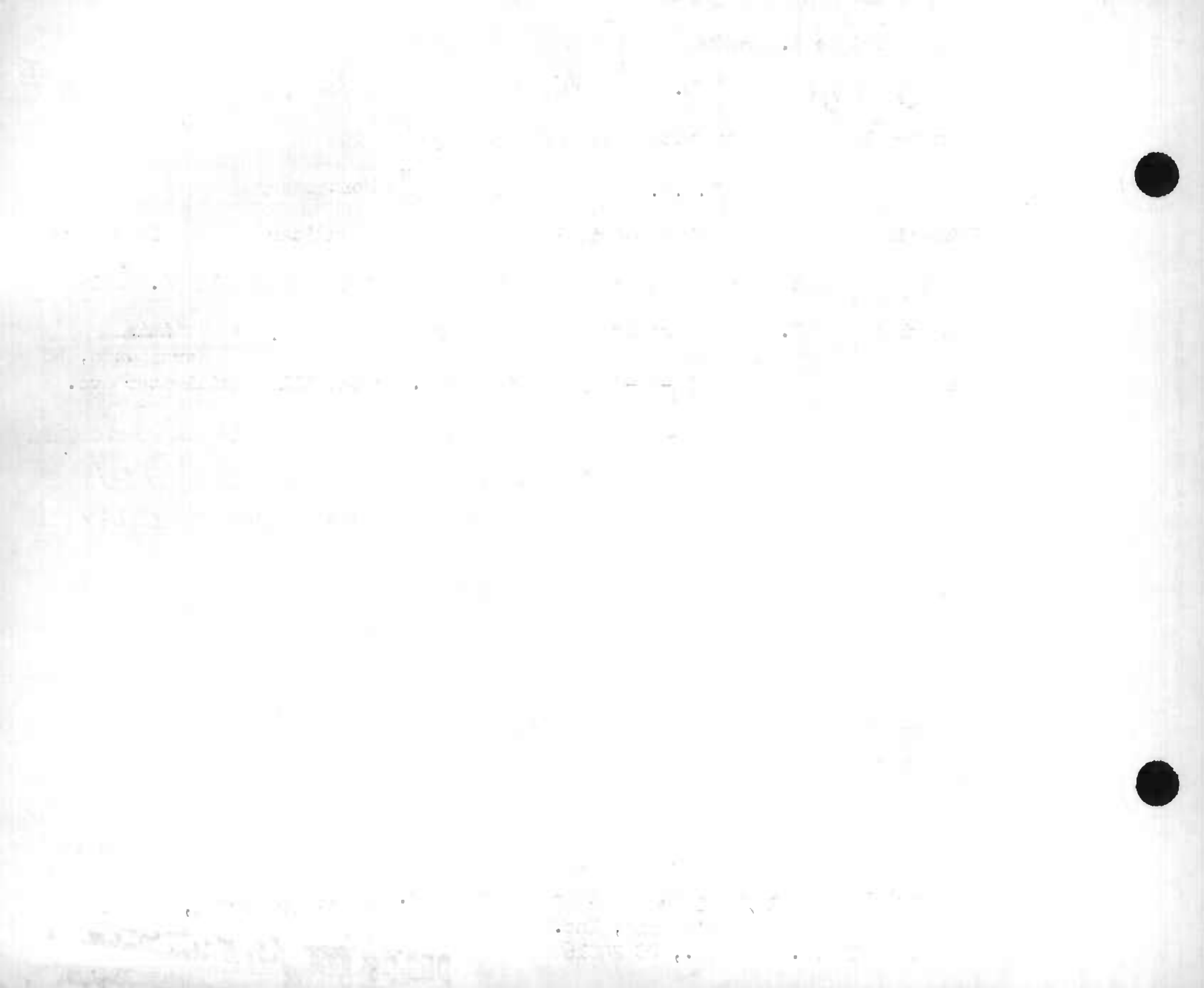
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1- STATE REGISTRAR Corinne E. Brooks

3 3 8 7 9
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CORRINE E. Brooks			2a. DATE OF DEATH MONTH DAY YEAR 12/20/84			2b. HOUR OF DAY 10 PM			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12/21/54		6. AGE (IN YEARS LAST BIRTHDAY) YRS 29		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auditor		12b. KIND OF BUSINESS OR INDUSTRY Insurance	
13a. STATE MD			13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Charles K. Brooks			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nelly Simie			13e. STREET ADDRESS / ZIP CODE 5225 Pooks Hill Rd. 20814			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-68-8543		17 INFORMANT Michele E. Brooks		ADDRESS Kensington, MD 11107 Stillwater Ave.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE PULMONARY EMBOLUS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) THROMBOPHLEBITIS DUE TO, OR AS A CONSEQUENCE OF (c) ACUTE NECROTIZING PANCREATITIS								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 1 DAY 5 DAYS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/16 , 19 84 , to 12/20 , 19 84 , that (I) (we) last saw the deceased alive on 12/20 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Daniel Powers, M.D.						DEGREE M.D.		22c. DATE SIGNED 12-20-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL POWERS, M.D.						22e. ADDRESS 50 W. EDMONSTON DR. ROCKVILLE, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/24/1984		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, MD			
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 WI Ave. NW Wash., DC 20016						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE John Davidson			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.


TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) Stephen KEISER Brooks					2a. DATE OF DEATH MONTH DAY YEAR 12-31-84					2b. HOUR 13:52 PM	
3 SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 7, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY N.I.H. Security guard			
13a. STATE Md		13b. COUNTY MONT		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 218 CROYDON AVE 20850			
14. FATHER'S NAME FIRST MIDDLE LAST Walter John Brooks				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude Keiser							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT Irene L. Brooks		ADDRESS Same as items 13a-e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION, GIVEN IN PART 1 (a) Malignant Lymphoma - histiocytic type diffuse											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 12-30 19 84, to 12-31 19 84, that (I) (we) lost saw the deceased alive on 12-30 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Donald L. Bucy				DEGREE MD				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-31-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald L. Bucy				22e. ADDRESS 809 DEERS Mill Rd Rockville, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/3/85		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park				23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland			
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland 20852						25a. DATE REC'D. BY REGISTRAR JAN 9 1985		25b. REGISTRAR'S SIGNATURE Jana Davidson-Randall			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										33881 REG. NO.	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) Benjamin T Brown			2a. DATE OF DEATH MONTH DAY YEAR 12 22 84			2b. HOUR 3:25 AM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 3 1908		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant		12b. KIND OF BUSINESS OR INDUSTRY Investment			
13a. STATE Maryland		13b. COUNTY PG		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6801 Forest Hill Dr 20782			
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin T. Brown, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nancy Bowen							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. ---		17. INFORMANT Dorothy B. Brown				ADDRESS Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Lung cancer with diffuse metastasis DUE TO, OR AS A CONSEQUENCE OF (c) 5 months										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic obstructive lung disease.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Tung P Lee		DEGREE 1st. Dr Sanderson				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/22/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) TUNG P LEE, M.D.		22e. ADDRESS 7411 Riggs Rd Hyattsville Md 20783									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 27Dec84		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md					
24. FUNERAL DIRECTOR NAME Robert E. Wilhelm Funeral Home		ADDRESS Suitland, Md		DATE REC'D. BY REGISTRAR DEC 28 1984							

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 3 8 8 2
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Ethel Collins Brown			2a. DATE OF DEATH MONTH DAY YEAR December 15, 1984		2b. HOUR A.M. 1:20 M.			
3 SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR October 2, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 15301 Beaver Brook Court #2G		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY Banking		
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Walter Washington Collins			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Schultz					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT (Daughter) ADDRESS 8809 Burdette Road Barbara B. Leighton, Bethesda, Maryland 20817				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Colon							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 Months	
DUE TO, OR AS A CONSEQUENCE OF (b) _____								
DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Coronary Artery Disease								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from Jan 31, 1982 , to December 15, 1984 , that (I) (we) lost saw the deceased alive on December 5, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I we) (did did not) view the body after death.								
22b. SIGNATURE <i>Daniel Goldberg</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED December 15, 1984		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Daniel Goldberg M.D.				22e. ADDRESS 10401 Old Georgetown Rd., Bethesda, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE December 17, 1984		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS Robert A. Pumphrey Funeral Homes, P.A. 7557 Wisconsin Avenue, Bethesda, Maryland				25a. DATE REC'D. BY REGISTRAR DEC 18 1984		25b. REGISTRAR'S SIGNATURE <i>Lia Davidson</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be
received by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page
should be detached for use at the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



CHIEF EXAMINER

EDUCATION



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

33883

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST John		MIDDLE J.	LAST Brown		2a. DATE OF DEATH		MONTH 12	DAY 29	YEAR 84	2b. HOUR 11:35A	
3. SEX M		4. RACE caucasian		5. DATE OF BIRTH		MONTH 4		DAY 27	YEAR 07	6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RHODE ISLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.							
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) POTOMAC VALLEY NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ARCH. ENGINEER				12b. KIND OF BUSINESS OR INDUSTRY H.U.D.			
13a. STATE MARYLAND				13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 700 DALE DRIVE 20910			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
FIRST WILLIAM				MIDDLE F.		LAST BROWN		FIRST MARY		MIDDLE L.		LAST McGOWAN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-32-0066		17. INFORMANT CELIA M. BROWN				ADDRESS SAME AS 13 WIFE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>multiple decubiti</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>urinary tract infection</u>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12/29</u> 19 <u>84</u> , to <u>12/29</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>12/29</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.													
22a. SIGNATURE <u>John J. Lawrence</u>								DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22b. PHYSICIAN'S NAME (TYPE OR PRINT)								22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 1/2/85		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN				23d. LOCATION CITY OR TOWN COUNTY MD. SILVER SPRING MONT MD.			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS								25. DATE REC'D. BY REGISTRAR JAN 4 1985		25b. REGISTRAR'S SIGNATURE <u>John J. Lawrence</u>			
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

33884
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
William Edward Brown, Sr.

2a. DATE OF DEATH MONTH DAY YEAR
12/29/84

2b. HOUR
5:25 AM

3. SEX
Male

4. RACE
Caucasian

5. DATE OF BIRTH MONTH DAY YEAR
January 7, 1909

6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.
75 YRS.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland

7b. CITIZEN OF WHAT COUNTRY?
United States

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD.

10. CITY OR TOWN OF DEATH
Rockville

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Sales Representative

12b. KIND OF BUSINESS OR INDUSTRY
Wholesale Foods

13a. STATE
Maryland

13b. COUNTY
Montgomery

13c. CITY OR TOWN
Gaithersburg

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS
19004 Montgomery Village Avenue

13f. Zip: 20879

14. FATHER'S NAME FIRST MIDDLE LAST
B. Herbert Brown, Sr.

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mabel Thompson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No

16b. SOCIAL SECURITY NO.
109-12-1144

17. INFORMANT ADDRESS
Mrs. Ruby D. Brown, Wife, Same as item #13

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) *Coma*
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) *Jaundice*
DUE TO, OR AS A CONSEQUENCE OF (c) *Hepatic failure*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: *Liver cirrhosis*

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from *December 18, 1984* to *December 29, 1984*, that (I) (we) last saw the deceased alive on *December 29, 1984*, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE
Baron K. Kim M.D.
22c. DATE SIGNED
12/29/84

22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Baron K. Kim

22e. ADDRESS
8921 Shady Grove Ct, Gaithersburg, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial

23b. DATE
December 31, 1984

23c. NAME OF CEMETERY OR CREMATORY
Parklawn Memorial Park

23d. LOCATION CITY OR TOWN COUNTY STATE
Rockville Maryland

24. FUNERAL DIRECTOR NAME
Robert A. Pumphrey Funeral Homes, P.A., Rockville, Maryland

25a. DATE REC'D. BY REGISTRAR
JAN 2 1985

25b. REGISTRAR'S SIGNATURE
Guth Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 3 8 8 5
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ALFRED LYTLE BURDINE			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 6 1984		2b. HOUR 7:21 P
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR MARCH 5 1900	6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, DC	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY County MD.		
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED Lawyer		12b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY	13c. CITY OR TOWN ROCKVILLE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST ALFRED HENRY BURDINE			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY ELIZABETH LYTLE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) 1941-1961	17. INFORMANT ADDRESS Maryland RUBY BURDINE, 219 FORREST AVENUE, ROCKVILLE, MD 20850		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) _____		
DUE TO, OR AS A CONSEQUENCE OF (c) _____		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

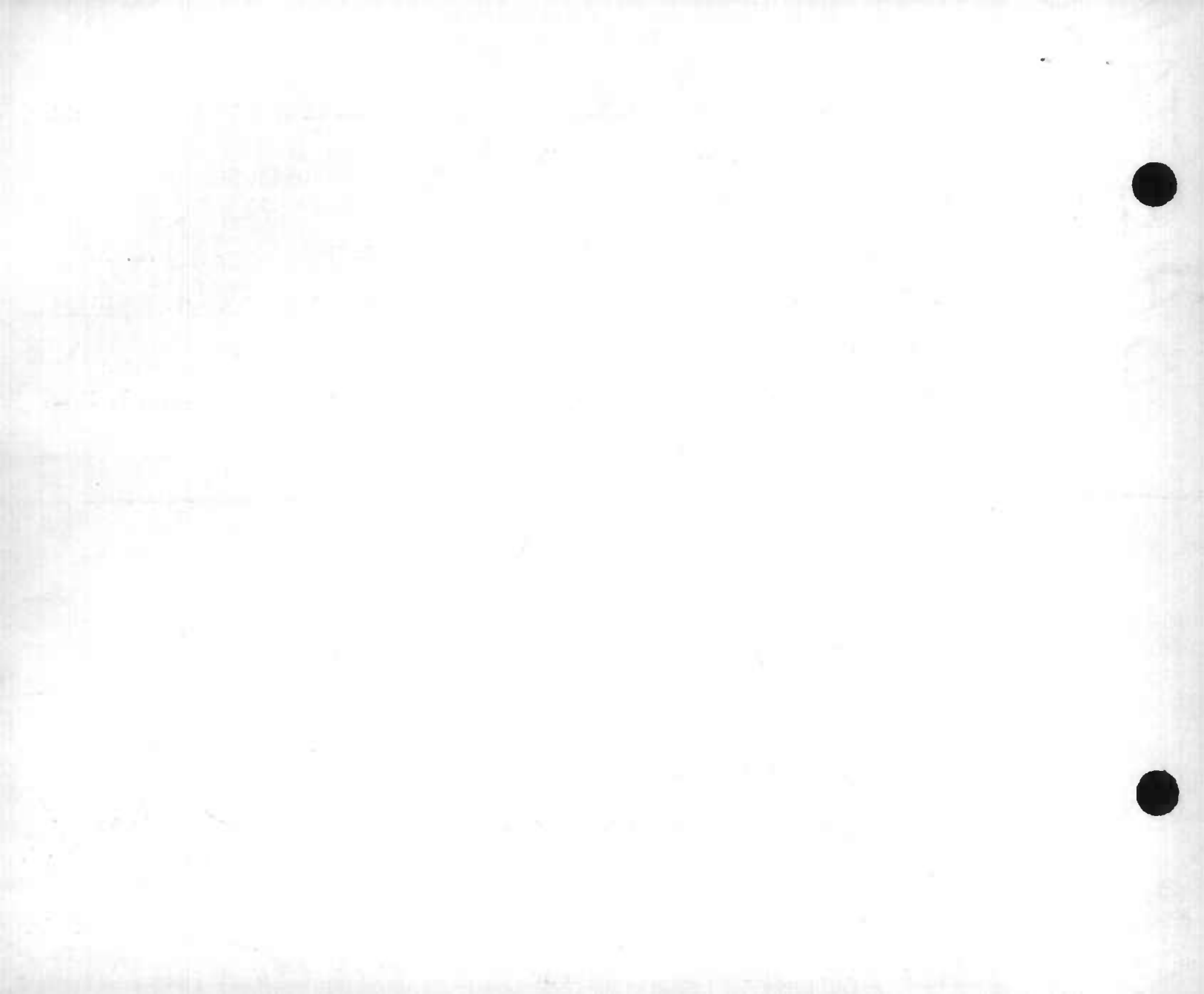
22a. I certify that (I) (this hospital) attended the deceased from **DECEMBER 3**, 19 **84**, to **DECEMBER 6**, 19 **84**, that (I) (we) last saw the deceased alive on **DECEMBER 6**, 19 **84**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <i>William A. Delacey</i>	DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 7 Dec 84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. A. DELACEY, LT, MC, USNR	22e. ADDRESS NAVAL HOSPITAL NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Dec. 11, 1984	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 10 1984 <i>John Davidson</i>	

Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Item 13a per phone Dr. Rogers

FOR 1/7/85 dad

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
STATE OF MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 33880

1. DECEASED NAME (TYPE OR PRINT) Rosa Lee Toon Cannady		2a. DATE KNOWN OF DEATH MONTH DAY YEAR Dec 27 1984		2b. HOUR 330 P M
3. SEX F	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR March 6 1970	6. AGE (IN YEARS) LAST BIRTHDAY 14 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Havelock, N. Car.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Havelock, N. Car.		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD		
10. CITY OR TOWN OF DEATH Havelock		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Holt Creek Hosp.		12. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.		13b. COUNTY N.C.		13c. CITY OR TOWN Havelock
14. FATHER'S NAME Dave		15. MOTHER'S MAIDEN NAME Alvania Barumna		16. SOCIAL SECURITY NO. Bobby Foreman
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dio. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None				
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion				
ACTUAL SIGNATURE John Rogers		TITLE (SPECIFY) M.D. Dep		DATE SIGNED Dec 27 1984
EXAMINER'S NAME (TYPE OR PRINT) John Rogers		ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/3/84		23c. NAME OF CEMETERY OR CREMATORY Hyman Chapel Church Cem. Havelock, NC.
24. FUNERAL DIRECTOR NAME Leroy O. Dyett		25. DATE REC'D. BY REGISTRAR DEC 28 1984		26. REGISTRAR'S SIGNATURE Lia Davidson-Randall

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DHMH - 17
(VR A15 ME (5))
20M 4/82



17th Dec 1950

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FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 3 8 8 1
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Antonietta S. Caruso			2a. DATE OF DEATH MONTH DAY YEAR 12 29 84		2b. HOUR 11 45 M
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 7 16 03		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ITALY	7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.
10. CITY OR TOWN OF DEATH TAKOMA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HECHT CO.	
13a. STATE MARYLAND		13b. COUNTY PRI. GEORGES	13c. CITY OR TOWN HYATTSVILLE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 578-20-6125		17. INFORMANT DAUGHTER ADDRESS 823 THURMAN AVENUE HYATTSVILLE, MD. 20783	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Possible Aspiration pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) acute Pulmonary Embolism Pneumonia Diabetes Mellitus					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (it) (they) did not know the body after death.					
22b. SIGNATURE Thomas J. Locke		DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas J. Locke, III MD		22e. ADDRESS 8580 Second Ave. Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/31/84		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN	
23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD PRI GEO MD.		23e. DATE REC'D. BY REGISTRAR JAN 4 1985			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS		25a. REGISTRAR'S SIGNATURE William H. Hordale			
25b. ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on item 19.

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				3 3 8 8 8 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Henson Thomas Cauffiel				2a. DATE OF DEATH MONTH DAY YEAR 12-08-84				2b. HOUR MIN 4:40p			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 05-18-15		6. AGE (IN YEARS LAST BIRTHDAY) YRS 69		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Wholesale Plumbing Representative		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1619 BELVEDERE BLVD 20902			
14. FATHER'S NAME FIRST MIDDLE LAST ALBERT F. CAUFFIEL				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAXINE RIBBLETT							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW II		17. INFORMANT ELIZABETH B. CAUFFIEL		ADDRESS SAME AS 13 WIFE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemoptysis DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Lung Cancer DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 5 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I, this hospital) attended the deceased from 15 Aug 84 to 8 Dec 84 that (I/we) lost saw the deceased alive on 15 Aug 84 and that in (my/our) opinion death occurred on the date and hour and from the causes stated above (I/we) (did/did not) view the body after death.											
22b. SIGNATURE Thomas A. Bensinger MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/8/84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas A. Bensinger MD		22e. ADDRESS 7525 Greenway Cir Drive Greenbelt MD 20770									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/12/84		23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE MONT MD.					
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901		25a. DATE REC'D. BY REGISTRAR DEC 13 1984		25b. REGISTRAR'S SIGNATURE P. Davidson-Randall			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR OUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 3 8 8 9
REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Philip		MIDDLE A.		LAST Caulfield		2a. DATE KNOWN OF ESTI. DEATH MATED		MONTH Dec		DAY 2		YEAR 1984		2b. HOUR M	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH Dec		DAY 23		YEAR 1905		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		10. CITY OR TOWN OF DEATH St. I. Sp. Holy Cross Hosp		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Medical Doctor		12b. KIND OF BUSINESS OR INDUSTRY Private Pract	
13a. STATE Md		13b. COUNTY Mont		13c. CITY OR TOWN Cherry Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1 E. Lenox St		20815		14. FATHER'S NAME FIRST Philip		MIDDLE E.		LAST Caulfield	
15. MOTHER'S MAIDEN NAME FIRST Grace		MIDDLE --		LAST Correll		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 216-38-5279		17. INFORMANT Wife		ADDRESS Same as #13		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <u>Chronic Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Yrs	
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? None		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		TITLE (SPECIFY) M.D. Dep.		MEDICAL EXAMINER		DATE Dec 2 1984		SIGNATURE John A. DeVol		ACTUAL SIGNATURE EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	
23b. DATE Dec 5, 1984		23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		23d. LOCATION CITY OR TOWN Rockville-Montgomery		COUNTY Md.		STATE		24. FUNERAL DIRECTOR NAME Robert A. DeVol		ADDRESS 2222 Wisc Ave. Washington D.C.		25a. DATE REC'D. BY REGISTRAR DEC 3 1984		25b. REGISTRAR'S SIGNATURE John Davidson Radell	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

33890
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nickitas E. Callas			2a. DATE OF DEATH MONTH DAY YEAR 12-25-84			2b. HOUR 10:16 AM				
3. SEX male		4. RACE caucasian		5. DATE OF BIRTH MONTH DAY YEAR 4-11-00		6. AGE (IN YEARS LAST BIRTHDAY) 84		7. (UNDER 1 YEAR) MONTHS DAYS (UNDER 24 HRS) HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GREECE		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RESTAURANTEUR		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN Maryland Montgomery Silver Spring				13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE 2601 Bel Pre Rd 20906				
14. FATHER'S NAME FIRST MIDDLE LAST ELIAS CALLAS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CHRISTOULA KAKARIS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 578-40-8174		17. INFORMANT NIECE		ADDRESS 6923 HAYCOCK ROAD FALLS CHURCH, VA. 22043			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Arterio sclerotic Heart disease PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7/11 19 84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/24 19 84 to 12/25 19 84 , that (I) (we) last saw the deceased alive on 12/24 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE R.T. Benack MD			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/25/84	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12/28/84		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.			
24. FUNERAL DIRECTOR NAME RANCIS J. COLLINS						25a. DATE REC'D. BY REGISTRAR DEC 31 1984				
25b. REGISTRAR'S SIGNATURE Gulie Davidson-Randell						25c. ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										33891			
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
VIRGINIA		J.		CHAFIN				12/21/84				12 20 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		Caucasian		July 11, 1905		79		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
West Virginia		United States				Montgomery County MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY U.S. GOVERNMENT							
Bethesda		Suburban Hospital		Worker		Social Service							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE					
Maryland		Montgomery		Bethesda				10620 Weymouth Street 20814					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST		FIRST MIDDLE LAST											
Robert Lee Jenkins		Mittie Hudson											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (Sister)		ADDRESS							
No		N/A		236-50-5787		Veda J. Batchelder Washington, D.C. 20010							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LIVER FAILURE													
DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CARCINOMA													
DUE TO, OR AS A CONSEQUENCE OF (c) MALIGNANT HEPATOMA													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 12/18/84 to 12/21/84, that (I) (we) last saw the deceased alive on 12/18/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		22c. DATE SIGNED											
Mark P. Weinstein MD		December 22, 1984											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
MARK P. WEINSTEIN MD		11125 Rockville Pike, Rockville, Maryland											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION							
Burial		December 26, 1984		Arlington National		Arlington						COUNTY Virginia	
24. FUNERAL DIRECTOR		25a. D. HEALTHY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Robert A. Pumphrey Funeral Homes, P.A. 7557 Wisconsin Ave., Bethesda, Maryland		DEC 24 1984		Jana Davidson									

BP

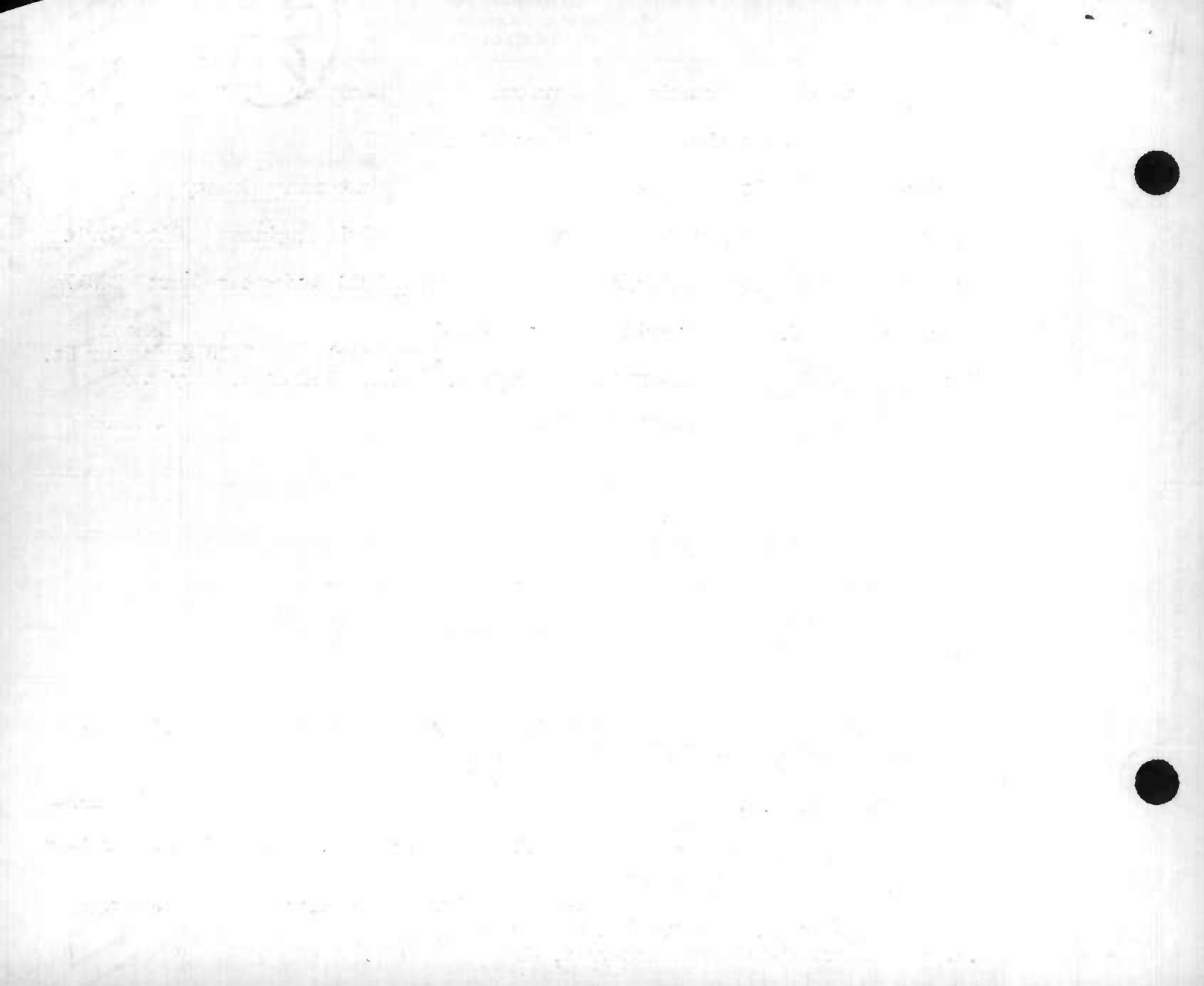


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		3 3 8 9 2 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Arthur Francis Charlton						December 22, 1984			6:20 P.M.		
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		Caucasian		January 19, 1897		87					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
New York		United States				Montgomery County			MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		7020 Barkwater Court				Civil Engineer		City Gov't			
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		
Maryland			Montgomery		Bethesda				7020 Barkwater Court 20817		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
Arthur C. Charlton			Fannie Lamont								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (Daughter)		ADDRESS					
Yes		WWI		116-28-3262		Arlyn C. Jurin, Bethesda, Maryland					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) Cancer of Colon									4 Months		
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Sept 4, 1984 to Sept 30, 1984, the (we) last saw the deceased alive on Sept. 30, 1984, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
Fred A. Gill, M.D.									12/23/1984		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
Fred A. Gill, M.D.			4743 Bradley Blvd., Chevy Chase, Maryland								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			27, 1984		St John's Cemetery		Yonkers New York				
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P.A. 7557 Wisconsin Avenue, Bethesda, MD						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
						DEC 24 1984		[Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										33893									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NANCY ELLEN CHEEK										2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 7, 1984										2b. HOUR 2:15 a									
3. SEX FEMALE					4. RACE WHITE					5. DATE OF BIRTH MONTH DAY YEAR APRIL 16, 1951					6. AGE (IN YEARS LAST BIRTHDAY) 33 YRS.					IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (STATE OR FOREIGN) CALIFORNIA					7b. CITIZEN OF WHAT COUNTRY? U.S.A.					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY, MD.														
10. CITY OR TOWN OF DEATH BETHESDA					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CLINICAL CENTER (NIH)										12a. USUAL OCCUPATION PHYSICAL THERAPIST					12b. KIND OF BUSINESS OR TYPE OF WORK FOR MOST OF WORKING LIFE HOSPITAL									
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE TEXAS										13b. COUNTY DALLAS					13c. CITY OR TOWN RICHARDSON					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET ADDRESS / ZIP CODE 1619 CENTENARY STREET 75081				
14. FATHER'S NAME FIRST MIDDLE LAST VERNON RUTHERFORD										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ARLENE BOWER																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) NO										16b. SOCIAL SECURITY NO. 442-56-3488					17. INFORMANT ADDRESS MR. RANDALL D. CHEEK (HUSBAND) SAME AS ABOVE ITEM #13														
MEDICAL CERTIFICATION										18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>BRAIN HERNIATION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>GLIOBLASTOMA MULTIFORMAE</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
										PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE																			
22a. I certify that (X) (this hospital) attended the deceased from <u>SEPT. 28,</u> 19 <u>84</u> , to <u>DEC. 7,</u> 19 <u>84</u> , that (X) (we) last saw the deceased alive on <u>DEC. 7,</u> 19 <u>84</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (XXX) view the body after death.										22b. SIGNATURE <u>Michael Nobles Baker, MD</u> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>										22c. DATE SIGNED <u>12-7-84</u>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Michael Nobles Baker, MD</u>										22e. ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MD 20205																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION					23b. DATE 12/8/84					23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY					23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA, VIRGINIA														
24. FUNERAL DIRECTOR RICHARD RAPP, INC. 1804 T ST., N.W., WASHINGTON, D.C. 20009										25a. DATE REC'D. BY REGISTRAR DEC 10 1984										25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>									

1804 T ST., N.W., WASHINGTON, D.C. 20000
RICHARD RAY, INC.
DISTRIBUTION 12/8/84
METROPOLITAN CEVATARY ALEXANDRIA, VIRGINIA

NO
VERNON
BUTTERFORD
AVERNE
BOKER
ST. 15081
PHYSICAL THERAPIST HOSPITAL
CALIFORNIA
U.S.A.

VOIDED DEATH CERTIFICATE NUMBER 84-33894

See Dwight Chetvetikoff died: 9/8/83 - Mont. Co.

Number 83-34592



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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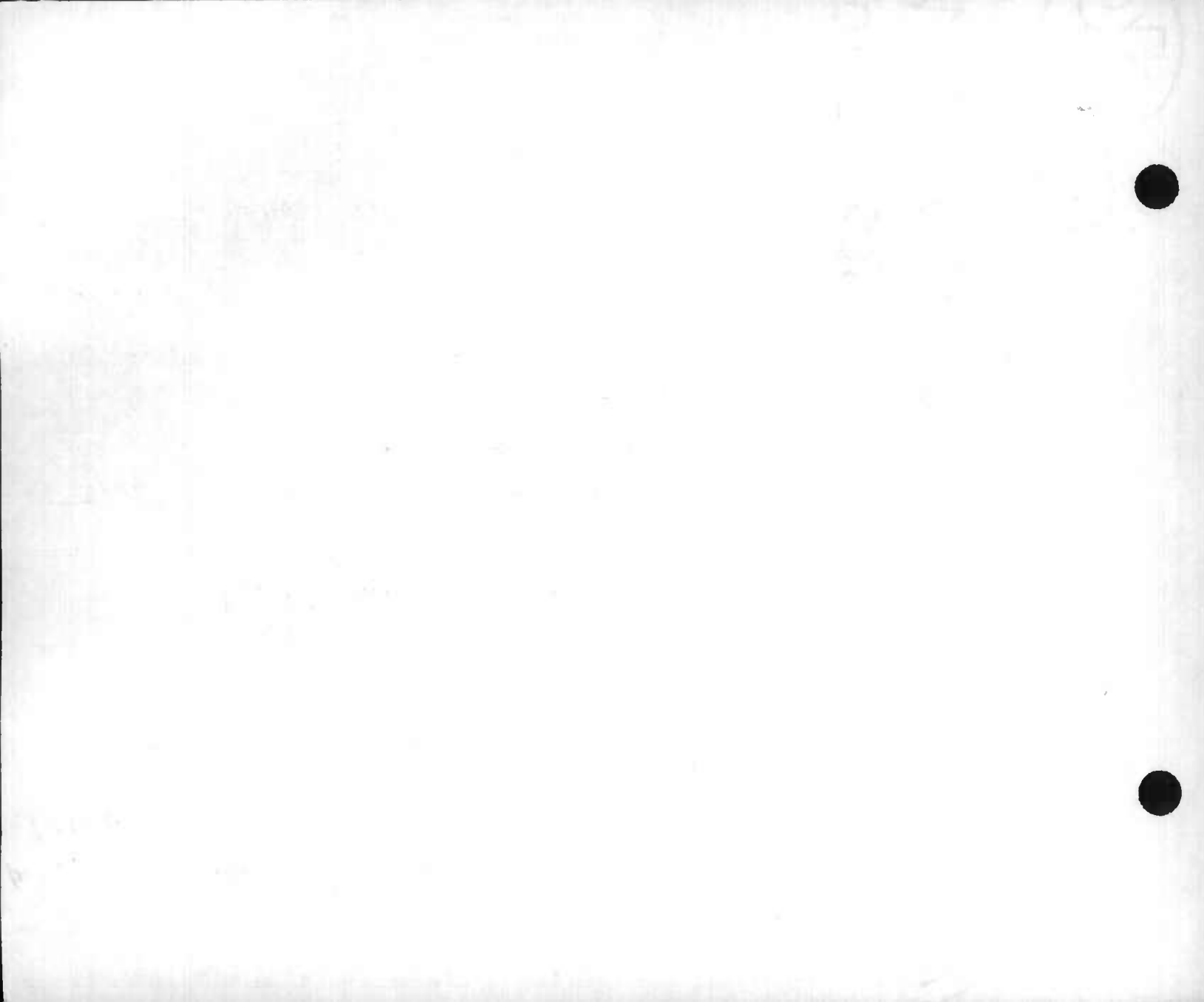
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

33895
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		HOURS MIN.	
Allison J. Chevalier		12-1-84		8:22P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	Black	MONTH DAY YEAR	32	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
TRINIDAD	Yes		Montgomery MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (LAST OF WORK FOR MOST OF WORKING YRS.)		12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring	Holy Cross Hospital		Secretary		Private
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. CITY OR TOWN	13c. INSIDE CITY LIMITS?	13d. STREET ADDRESS / ZIP CODE		
MD	MPG	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	7600 MAPLE AVE #311		
14. FATHER'S NAME (FIRST MIDDLE LAST)		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)			
LEON		LEWIS		MONICA LEWIS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		217-88-658		CARL CHEVALIER 7600 MAPLE AVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septis with E. coli.</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Peritonitis</u>					3 days
(c) <u>Due to, or as a consequence of</u>					3 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Chronic Renal Failure, Sickle Cell Anemia, Cardiomyopathy</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
		P.M. 19			
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION (CITY OR TOWN, COUNTY, STATE)	
22a. I certify that (1) this hospital attended the deceased from <u>1 mo</u> 19 <u>84</u> , to <u>1 mo</u> 19 <u>84</u> , that (1) (we) last saw the deceased alive on <u>1 mo</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
James H. Knepsnield, MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		2 Dec 1984	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
James H. Knepsnield, MD		4905 Def Ray Ave, Bethesda, MD 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		12-5-84		HARMONY	
24. FUNERAL DIRECTOR NAME		24b. DATE REC'D. BY REGISTRAR		24c. REGISTRAR'S SIGNATURE	
Johnson & Jenkins		DEC 12 1984		Lelia Davidson-Randall	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					3 3 8 9 6 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Harold Francis Chrisman					2a. DATE OF DEATH MONTH DAY YEAR 12/23/84			2b. HOUR 415 A M	
3. SEX M		4. RACE caucasian		5. DATE OF BIRTH MONTH DAY YEAR 9 18 02		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) OREGON		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH TR PK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY ARMY	
13a. STATE MD		13b. COUNTY MONTG		13c. CITY OR TOWN SS MD		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9204 WILMER ST 20901	
14. FATHER'S NAME FIRST MIDDLE LAST FRANK CHRISMAN					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CECILE VICTORIA BARZEE				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Retired Army					16b. SOCIAL SECURITY NO. 564 42 7048		17. INFORMANT ADDRESS Chart		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ PULMONARY Edema Pneumonia Pancreatitis Aneurysm									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 12-12-84 to 12-23-84, that (I) (we) last saw the deceased alive on 12-23-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE W H Ferguson MD					DEGREE MD			22c. DATE SIGNED 12-23-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W H Ferguson					22e. ADDRESS 344 UNION BLVD W SS MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec 27, 1984		23c. NAME OF CEMETERY OR CREMATORY Plymouth National Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Va		
24. FUNERAL DIRECTOR NAME Takara Funeral Home, 2510 Hilltop, 2510 Hilltop, 2510 Hilltop					25a. DATE REC'D. BY REGISTRAR DEC 27 1984				
25b. REGISTRAR'S SIGNATURE A. L. K. K. K. K. K.									

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

33897
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST		12/30/84 3:10 PM	
Irene N. Chumak							
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female	CAUCASIAN	NOV. 25 1891		93		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
GREECE	U.S.A.			Montgomery MD		HOUSEWIFE	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY		
Kensington	Kensington Gardens Nursing Center						
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS		
MARYLAND		MONTGOMERY	SILVER SPRING	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	3923 TIFORD ROAD 20906		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES?			
DEMETRIOS		KOSKOURAS		NO (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			
16a. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
578-30-1609		DAUGHTER		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory failure DUE TO, OR AS A CONSEQUENCE OF (b) Obstructive jaundice DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of liver Approximate interval between onset and death: 1 day, 3 months, 4 months.			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY			
YES <input type="checkbox"/> NO <input type="checkbox"/>				HOUR A.M. MONTH DAY YEAR			
				P.M. 19			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED		21e. PLACE OF INJURY			
		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
				21f. LOCATION			
				STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Sept. 5, 1980, to Dec. 30, 1984, that (I) (we) lost saw the deceased alive on 12-21-1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
		TUNG P. LEE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		12/30/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			
TUNG P LEE MD		7411 Riggs Rd Hyattsville MD		BURIAL			
23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
1/3/85		GLENWOOD CEMETERY		WASHINGTON, D. C.			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
FRANCIS J. COLLINS		JAN 4 1985		Lillian Davidson Randall			
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR 1- STATE REGISTRAR		FOR DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH 3 3 8 9 8											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH ESTI- MATED		MONTH DAY YEAR		2b. HOUR 19	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR 19	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS				20902	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS									
No				Halina Knas Daughter Same as 13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost (b) <u>Chronic Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Xrx.</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
None													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED							
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS											
John S. Rogers, M.D.		1919 Seminary Road Silver Spring, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		1/3/85		St. John's Cemetery		Forest Glen Montgomery Md.							
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Francis J. Collins		JAN 4 1985		J. Davidson-Rendell									
500 University Blvd., W. Silver Spring, Md.													

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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500 University Blvd., St. Silver Spring, Md.
Francis J. Collins
11/1/55 St. John's Cemetery
Forest Glen Mortuary, Md.

1919 Cemetery, Fort Silver Spring, Md.
Forest Glen Mortuary, Md.

Anthony

Elizabeth

John

Paul

John's First Daughter, born as 17

Charles

1900

Poland

Poland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 33899

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nicholas Joseph CITTADINO			2a. DATE OF DEATH MONTH DAY YEAR 12 6 84			2b. HOUR 4:35 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 30 27		6. AGE (IN YEARS LAST BIRTHDAY) 56		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lithographer		12b. KIND OF BUSINESS OR INDUSTRY Graphics Print.			
13a. STATE Maryland		13b. CITY OR TOWN Montgomery		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 10608 Edgewood Avenue 20901			
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Cittadino			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Simeone						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 578-34-3455		17. INFORMANT Mary G. Cittadino Mother		ADDRESS Same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45 minutes	
DUE TO, OR AS A CONSEQUENCE OF (b) Acute MYOCARDIAL Infarction								36 hours	
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:10									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 12-6-84 to 12-6-84 , that (I) (we) lost saw the deceased alive on 12-6-84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John A. Galotto M.D.			22c. DATE SIGNED 12-6-84						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John A. Galotto M.D.			22e. ADDRESS 5225 Pooks Hill Road Bethesda, Md 20854						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 10, 1984		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Maryland		
24. FUNERAL DIRECTOR NAME Francis J. Collins					24b. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE DEC 10 1984 John Davidson-Randall				
500 University Blvd., W. Silver Spring, Md.									

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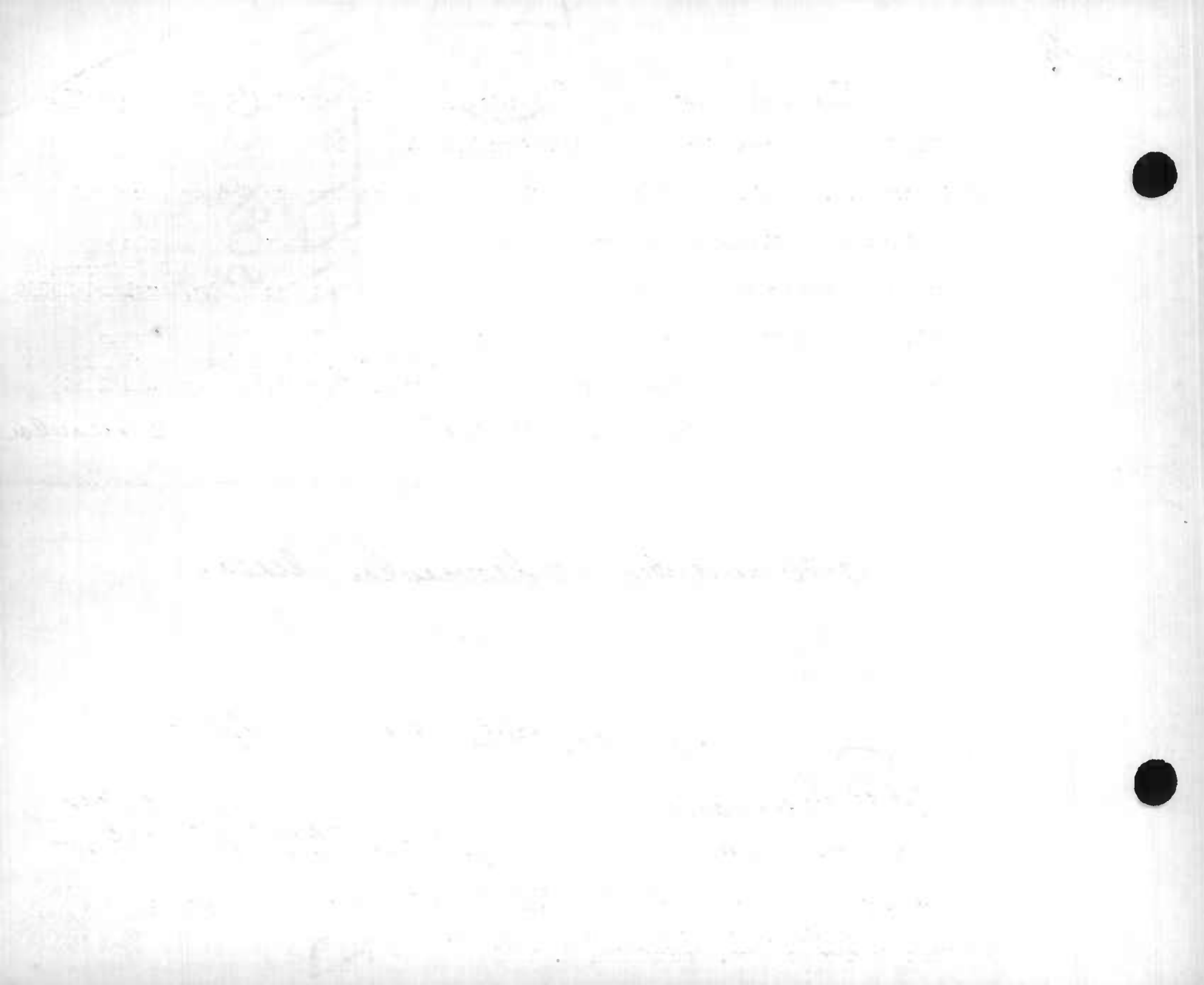


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR 1- STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Isabel A. Clark					2a. DATE OF DEATH MONTH DAY YEAR December 6, 1984			2b. HOUR 4:45p M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR September 7, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County Maryland MD.			
10. CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Circle Manor Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 528 Anderson Avenue Rockville, Maryland 20850	
14. FATHER'S NAME FIRST MIDDLE LAST Louis Cass Johnson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Isabella Evans				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (# YES, GIVE WAR OR DATES) 577-88-5896		17. INFORMANT Shirley C. Arant (Daughter) 528 Anderson Avenue Rockville, Maryland 20850					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 seconds</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>arteriosclerotic cardiovascular disease</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>9/6</u> <u>84</u> to <u>9/6</u> <u>84</u> , that (I) (we) last saw the deceased alive on <u>9/6</u> <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>B.N. ROSENBAUM, M.D.</u>		DEGREE		22c. DATE SIGNED <u>9/6/84</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>B.N. ROSENBAUM</u>				22e. ADDRESS <u>3720 FARRAGUT AVE. KENSINGTON, MD 20895</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE December 7, 1984		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey				24b. ADDRESS 300 West Montgomery Ave. Rockville, Md. 20850		25. DATE REC'D. BY REGISTRAR DEC 10 1984			
				25b. REGISTRAR'S SIGNATURE <u>John Davidson-Rodell</u>					



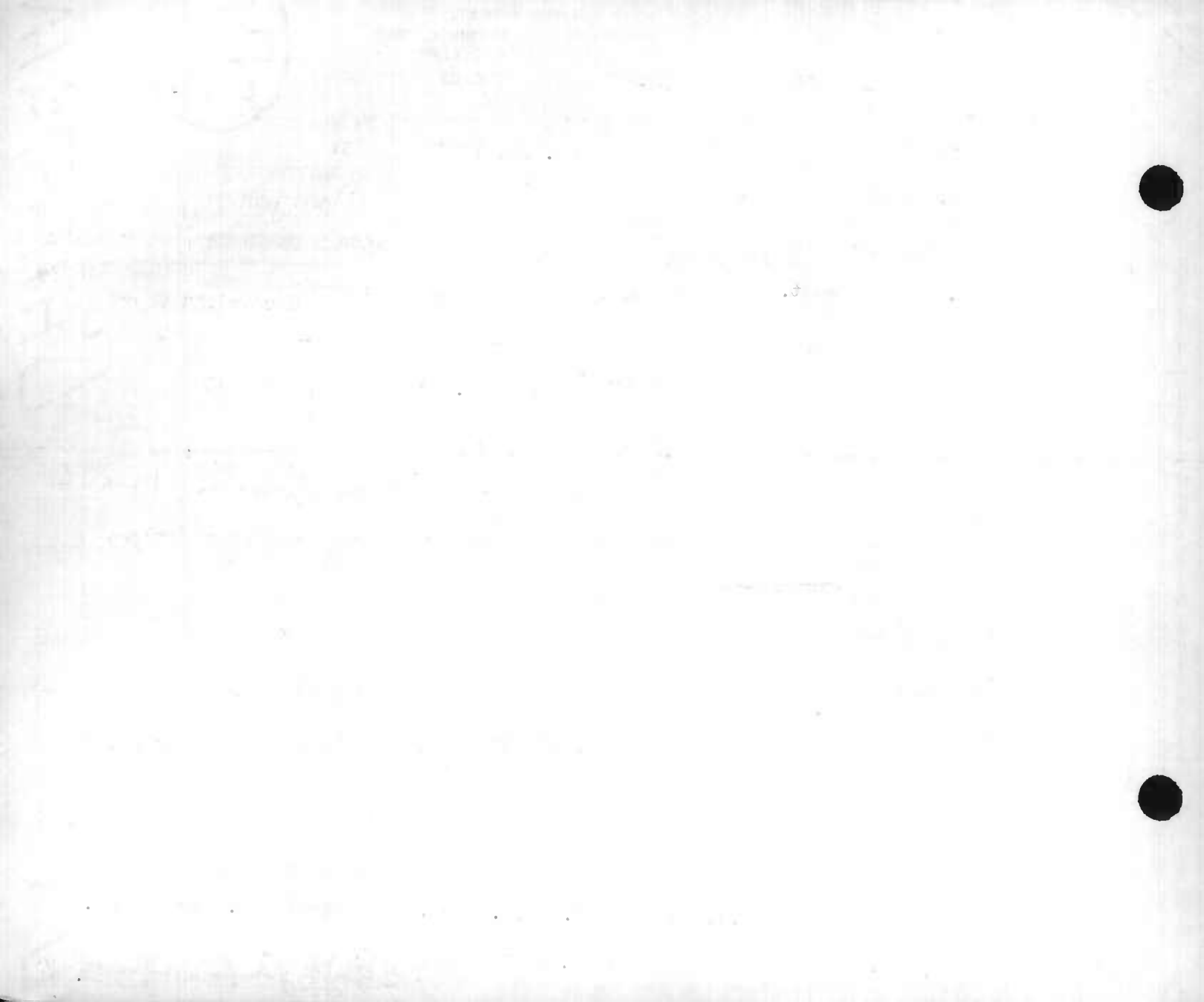
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 33901	
1. DECEASED NAME (TYPE OR PRINT) JO ANN CLARK						2a. DATE OF DEATH MONTH DAY YEAR 12 02 84			2b. HOUR 4:30 P.M.		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR AUG. 20, 1933		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN) WEST VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK, FORM, INDUSTRY, ETC.) FLORAL DESIGNER		12b. KIND OF BUSINESS OR INDUSTRY FLORIST			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY Mont. 13c. CITY OR TOWN Gaithersburg 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						13e. STREET ADDRESS / ZIP CODE 10450 Kardwright Court 20879					
14. FATHER'S NAME FIRST MIDDLE LAST ASA WESLEY PRICE				15. MOTHER'S MAIDEN NAME MIDDLE LAST NANNIE HATCHER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO. 234-56-6106		17. INFORMANT ADDRESS Jack E. Clark Same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRAIN DEATH DUE TO, OR AS A CONSEQUENCE OF (b) Syndrome increased intracranial pressure DUE TO, OR AS A CONSEQUENCE OF (c) Subarachnoid hemorrhage due to ruptured aneurysm Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION NC			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NC			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11/29 , 19 84 , to 12/2 , 19 84 , that (I) (we) lost saw the deceased alive on 12/2 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE [Signature]			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/2/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bernard Fork MD						22e. ADDRESS 5530 W. Fennell Ave Ch. Ch. Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE DEC. 5, 1984		23c. NAME OF CEMETERY OR CREMATORY Balt. Wash. Crem.			23d. LOCATION CITY OR TOWN COUNTY STATE Laurel P. George Md.			
24. FUNERAL DIRECTOR NAME FRANCIS H. BARBER LAYTONSVILLE, MD. 20879						25a. DATE REC'D BY REGISTRAR DEC 6 1984		25b. REGISTRAR'S SIGNATURE [Signature]			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										33902 REG. NO.						
1. FOR STATE REGISTRAR					2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)					FIRST		MIDDLE		LAST		12		18 84 4:33 P.M.			
Mabel S. Cline					3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR			
Female					W		10 28 04		80 YRS.		MONTHS		DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH	
West Virginia					U.S.A.					Montgomery					MD.	
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY	
Takoma Park					Washington Adventist Hospital					House wife					Own Home	
13a. STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS?	
Maryland					P. G.					Edmonston					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.	
George Ransome					Corey Smar					No					212 24 4483	
17. INFORMANT					4908 49th Avenue					Bobby D. Cline					Edmonston, Md. 20781	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
IMMEDIATE CAUSE (a) metastatic breast cancer										8 yrs.						
DUE TO, OR AS A CONSEQUENCE OF																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																
DUE TO, OR AS A CONSEQUENCE OF																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:																
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
					HOUR A.M. MONTH DAY YEAR											
					P.M. 19											
21d. INJURY OCCURRED					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION						
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from July 19 83 to Dec 19 84, that (I) (we) last saw the deceased alive on 12-18 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) did not view the body after death.										22c. DATE SIGNED						
22b. SIGNATURE										DEGREE		22e. ADDRESS				
Ka-Yin Yeung MD												8926 Woodyard Rd #201 Clifton, MD 20735				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY						
Burial					12/22/84					Fort Lincoln Cemetery						
										23d. LOCATION						
										CITY OR TOWN COUNTY STATE						
										Brentwood, Md.						
24. FUNERAL DIRECTOR										25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Francis GASCH'S Sons Funeral Home										DEC 24 1984		J. W. Anderson - Nordall				
4739 Baltimore Avenue Hyattsville, Md. 20781																



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) Calvin Cochran						2a. DATE KNOWN OF DEATH ESTIMATED XX 12-14 1984		2b. HOUR 2:00 p.m.	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR OCT. 5, 1907	6. AGE (IN YEARS) LAST BIRTHDAY 77 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12-16 1984	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MAINE		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WEATHERMAN			
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8029 EASTERN AVE #207				12c. KIND OF BUSINESS OR INDUSTRY WEATHER BURE		12d. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md. MONTGOMERY SILVER SPRING	
13a. STATE Md.		13b. CITY OR TOWN MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8029 EASTERN AVE, #207, 20910	
14. FATHER'S NAME FIRST MIDDLE LAST MILTON T. COCHRANE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZA G. PLACE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 577-60-1040		17. INFORMANT ADDRESS RICHARD C. COCHRANE #16 LINDA LA. BETHEL, CONN. 06801					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Dennis F. Smith</i>				TITLE (SPECIFY) Assistant		MEDICAL EXAMINER		DATE SIGNED 12-17-84	
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smith, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 12-19-1984		23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE, P.G., C. Md.	
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO. INC. SILVER SPRING, Md.				25a. DATE REC'D. BY REGISTRAR DEC 24 1984		25b. REGISTRAR'S SIGNATURE <i>Leta E. ...</i>			

20% COTTON FIBRE

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INDIA



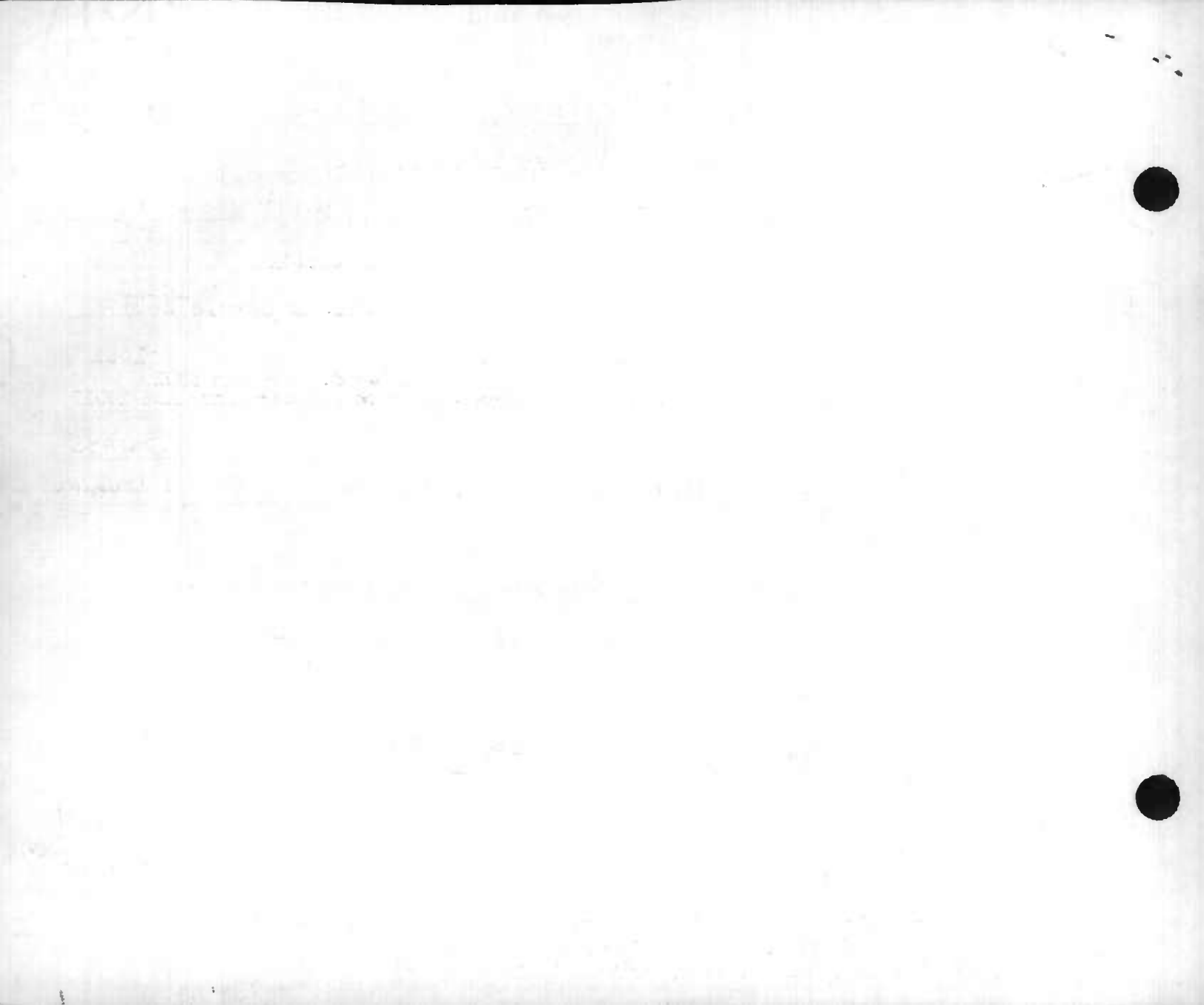
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 33904

1. DECEASED NAME (TYPE OR PRINT) DOROTHY COCHRANE			2a. DATE OF DEATH MONTH DAY YEAR 12-20-1984			2b. HOUR MIN. 945 A				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR August 20, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 82		7. UNDER 1 YEAR MONTHS DAYS YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Scotland		7b. CITIZEN OF WHAT COUNTRY? Great Britain		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Arizona Circle 10225 20817	
14. FATHER'S NAME FIRST MIDDLE LAST Philip DiMarco			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Pelosi			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				
16b. SOCIAL SECURITY NO. 579-82-8895			17. INFORMANT ADDRESS William J. Cochrane 6302 Conlenlion Court Bethesda, Maryland 20817							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC BREAST CANCER DUE TO, OR AS A CONSEQUENCE OF (c) 1 1/2 years APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Congestive heart failure, Pneumonia, urinary tract infection										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/20 19 84 to 12/20 19 84 , that (I) (we) lost saw the deceased alive on 12/20 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Martyn Kanovsky			DEGREE			22c. DATE SIGNED 12/20/84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTYN KANOVSKY, MD			22e. ADDRESS 5401 WESTERN AVE NW WASHINGTON, DC 20015			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE December 22, 1984		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria, Virginia		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey ADDRESS Funeral Homes PA. 7557 Wisconsin Ave Bethesda, Maryland 20814						25a. DATE RECEIVED BY REGISTRAR DEC 24 1984				

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 3 9 0 5

1 - FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) ROSE COHEN			2a DATE OF DEATH MONTH DAY YEAR 12-27-84			2b HOUR 8:55 A M	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 03-08-04		6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Chevy Chase R&N Center				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	
12b KIND OF BUSINESS OR INDUSTRY AT HOME		13a STREET ADDRESS / ZIP CODE 1131 UNIV. BLVD. WEST 20902					
13b STATE MARYLAND		13c CITY OR TOWN SILVER SPRING		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e APT. 1508	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH Bernstein				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDITH LAMAR			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-50-9220		17. INFORMANT JEFFERY COHEN 911 La GRANDE RD. SILVER SPRING, MD 20903			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Respiratory Arrest.

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

8:55 A.M. 12/27/84

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Aspiration - Sepsis - Pneumonia

DUE TO, OR AS A CONSEQUENCE OF

(c) Organic Brain Syndrome.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/10/84 to 12/27/84, that (I) (we) last saw the deceased alive on 12/10/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE PENNY BISK				DEGREE MD		22c. DATE SIGNED 12/27/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PENNY BISK				22e. ADDRESS 10301 GEORGETOWN AVE JENNINGS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC. 28, 1984		23c. NAME OF CEMETERY OR CREMATORY CHIZUK AMUNO		23d. LOCATION BALTIMORE COUNTY MARYLAND	
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24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. NAME ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR JAN 3 1985		25b. REGISTRAR'S SIGNATURE na Davidson-Randall	
---	--	--	--	---	--	---	--

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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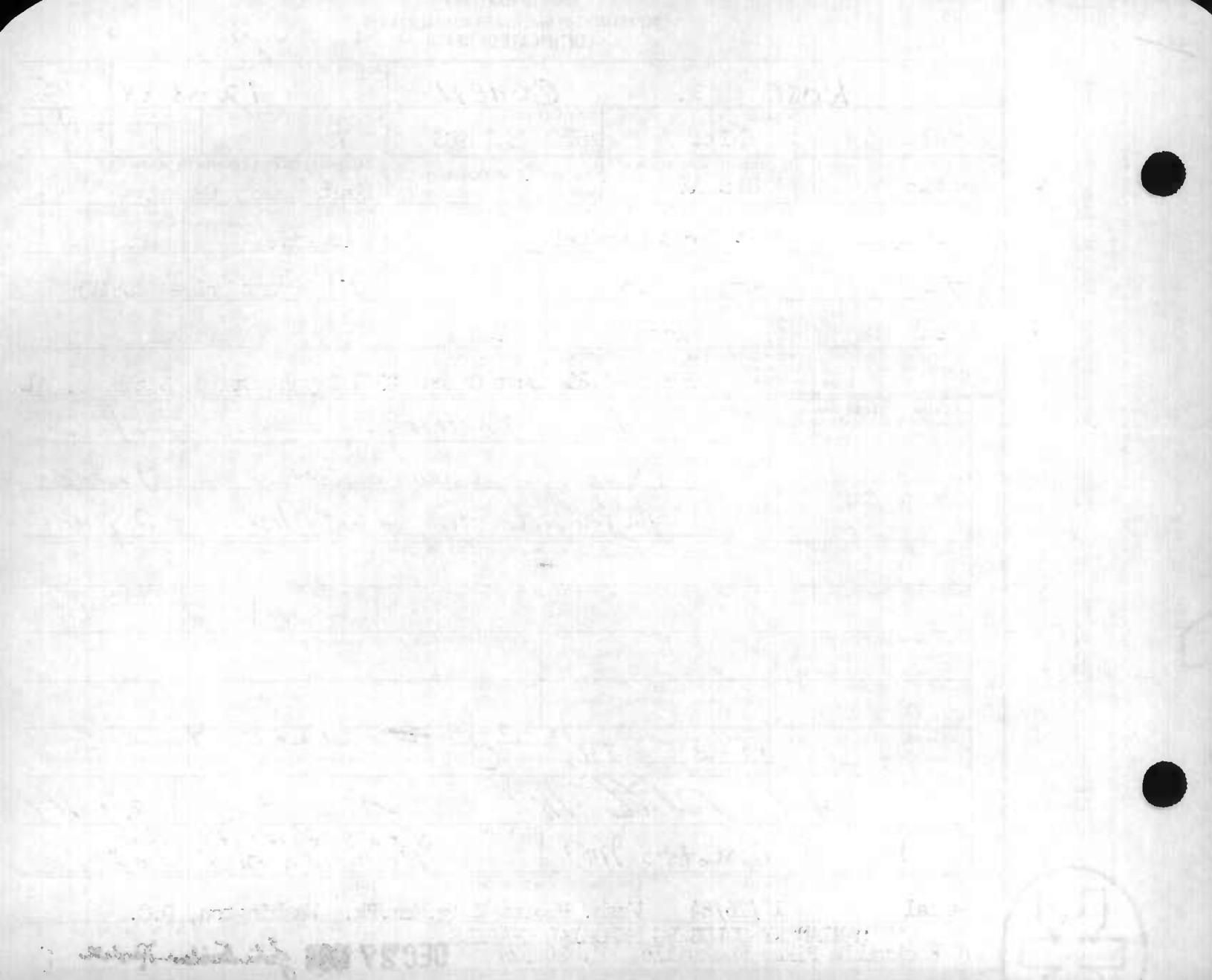
10-15-02

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. STATE REGISTRAR		STATE OF MARYLAND		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		CERTIFICATE OF DEATH		REG. NO. 33906	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		2b. HOUR			
ROSE R. COHEN				12-23-84		1:45 PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		White		April 19, 1905		79		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Russia		U.S.A.				Montgomery County, MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Holy Cross Hospital				Housewife		Home	
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland				Montgomery		Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS			
Abraham				Roseff		8301 Bryant Drive (20817)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No				398-52-4785		Burt Cohen; 8301 Bryant Drive; Bethesda, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u>								1 hour	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Cardiomyopathy</u>								2 weeks	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u>								2 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12-13-84</u> to <u>12-23-84</u> , that (I) (we) last saw the deceased alive on <u>12-23-84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
John A. Galotto MD.								12/23/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
				5225 Park Hill Rd Bethesda Md 20814					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		12/26/84		Wash. Hebrew Cong. Mem. Pk.; Washington, D.C.		CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR			
DANZANSKY-GOLDBERG MEMORIAL CHAPELS						25b. REGISTRAR'S SIGNATURE			
1170 Rockville Pike; Rockville, Md. 20852						DEC 27 1984 John A. Galotto			

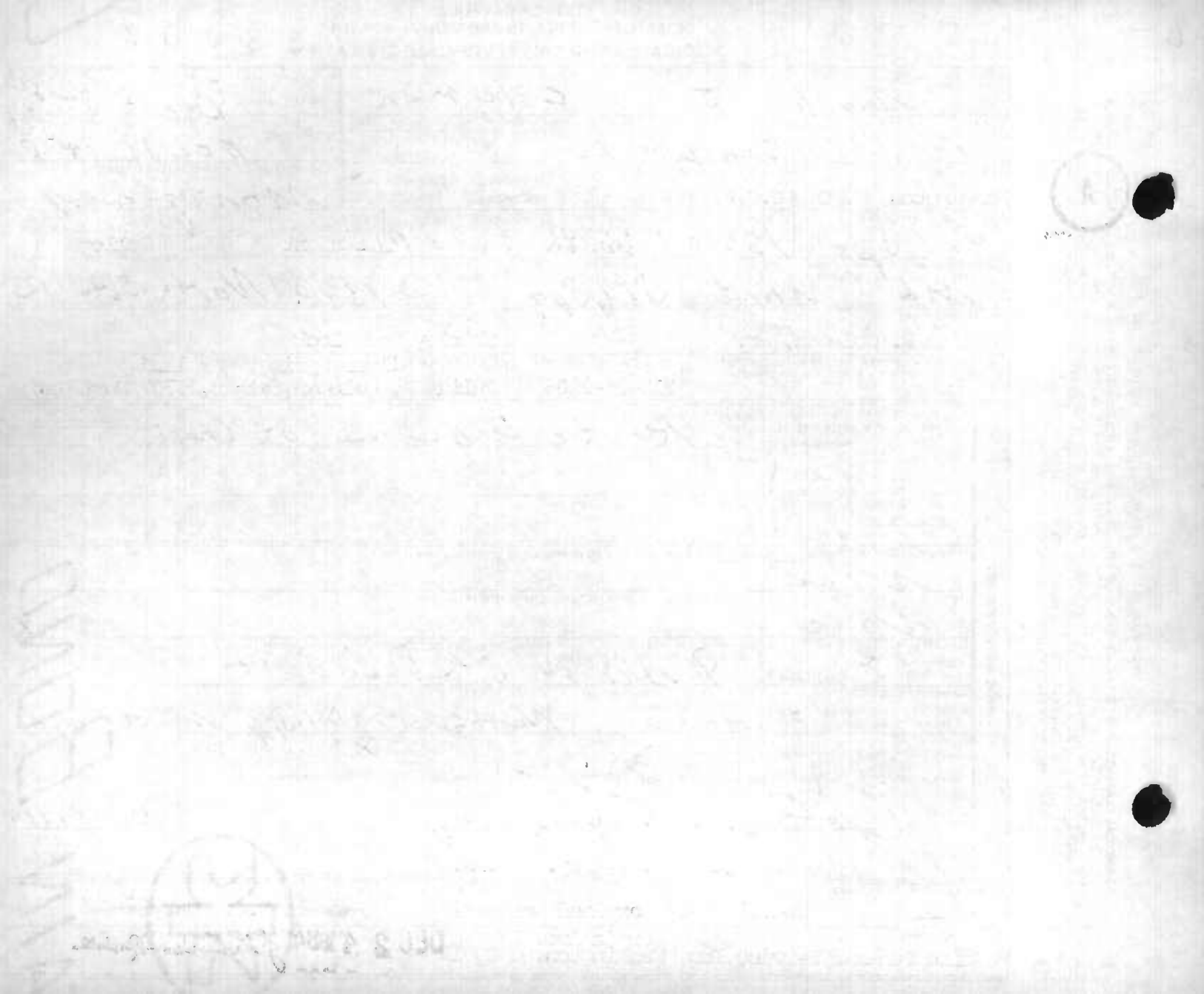


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IN EXECUTING THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

#23c,d,FilmG599 1/14/85 kam											
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 33907											
REG. NO.											
1- STATE REGISTRAR						2a. DATE KNOWN OF DEATH					
1. DECEASED NAME (TYPE OR PRINT)						2b. DATE OF DEATH					
Mark J. Coleman						Dec 18 1984					
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.	
M		Blk		Jan 12 1964		20 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
Washington, D. C.				U.S.A.				9. BALTIMORE CITY OR COUNTY OF DEATH			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
S. L. Spg.				13707 North Gate Rd				Student			
13a. STATE				13b. COUNTY				13c. STREET ADDRESS			
Md				Mont.				13707 North Gate Rd			
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME					
Julius R. Coleman, Sr.						Shirley Mae Black					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.		17. INFORMANT			
No						218-94-2206		Silver Spring, Maryland			
								Julius R. Coleman, father, 13707 North Gate			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Knife Wound of Chest											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
None											
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					
None											
20. AUTOPSY?						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY					
						Hour A.M. MONTH DAY YEAR					
						P.M. 0 11 18 84					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)					
						Home					
21f. LOCATION						21g. LOCATION					
						North Gate Dr. S. L. Spg. Monte Md.					
22a. I certify that I took charge of the remains described above, held on											
Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE						TITLE (SPECIFY)					
John S. Rogers, M.D., Dep. Med. Ex.						MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT)						DATE SIGNED					
						Dec 18 1984					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)						23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			
Burial						Dec. 22, 1984		Maryland National			
23d. LOCATION						23e. DATE RECD. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE			
Wheaton, Mont. Md.						DEC 24 1984		John S. Rogers			
24. FUNERAL DIRECTOR						25. DATE OF DEATH					
McGuire Funeral Service, Inc., Washington, DC 20012						DEC 24 1984					



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH-33908
REG. NO.1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MYRTLE G. COLLIER			2a. DATE OF DEATH MONTH DAY YEAR 12 2 84		2b. HOUR 5:30 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 5, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Gaithersburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wilson Health Care Conv. Ctr.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Agent	12b. KIND OF BUSINESS OR INDUSTRY Real Estate	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1103 Ramblewood Road, 21239
14. FATHER'S NAME FIRST MIDDLE LAST David Henry Gough		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Tankersley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 214 34 3116		17. INFORMANT ADDRESS J. Lyle Beauchamp, Towson, MD	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

(b) Cerebral aneurysm

DUE TO, OR AS A CONSEQUENCE OF

(c) Atherosclerosis

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lastAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

1 day

years

years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):

swelling

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 (a) OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

CITY OR TOWN COUNTY STATE

21g. WHERE AT WORK ☐ NOT WHITE ☐
AT WORK AT WORK

22a. I certify that (I) (this hospital) attended the deceased from

saw the deceased alive on

11/27/83

and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

22b. SIGNATURE

DEGREE

ATTENDING

MEDICAL

STAFF

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION
CITY OR TOWN

COUNTY STATE

24. FUNERAL DIRECTOR
NAME

Henry W. Jenkins & Sons Co.

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

4905 York Road Balto., MD 21212

DEC

4 1984

Julia Davidson Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or blank, it shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.



1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

33909
REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Ellen I. COLLINS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-10-84 | | | 2b. HOUR
1035 PM | | | |
| 1. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
4 23 23 | | 6. AGE (IN YEARS LAST BIRTHDAY)
61 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 2 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash. DC | | 7b. CITIZEN OF WHAT COUNTRY?
US | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
How Cross Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
US Govt. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
9310 Wire Avenue 20901 | |

| | | | |
|--|--|--|--|
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William J. Collins | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Catherine V. Sheahan | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
N/A | | 16b. SOCIAL SECURITY NO.
578-44-4738 | |
| 17. INFORMANT
Maurice W. Collins-brother- | | ADDRESS
3122 Belts. Rd. Belts, Md. 20705 | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) hepatic failure
DUE TO, OR AS A CONSEQUENCE OF (b) hepatocellular carcinoma
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) 6 weeks | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 days |
|---|--|---|

| | | | |
|---|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
endometrial carcinoma | | | |
|---|--|--|--|

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/3 , 19 84 , to 12/10 , 19 84 , that (I) (we) last saw the deceased alive on 12/10 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Bruce A. Silver, MD | | | | DEGREE
MD | | 22c. DATE SIGNED
12/11/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BRUCE A. SILVER, MD | | | | 22e. ADDRESS
106 Irving St., N.W. Wash DC 20010 #421 | | | |

| | | | | | | | |
|---|--|-----------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Dec. 13, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Mount Olivet | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, DC | |
| 24. FUNERAL DIRECTOR
NAME
Hines/Rinaldi Funeral Home | | | | ADDRESS
11800 N.H. Ave., Silver Spring, Md. | | 25a. DATE REC'D. BY REGISTRAR
DEC 12 1984 | |



218-44-873

CHIEF

80%



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4, 5, AND 6 TO THE MEDICAL EXAMINER. ALONG WITH FORM PM. 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/B2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

3 3 9 1 0

FOR
1- STATE
REGISTRAR

| | | | | | |
|--|-------------------------|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Mary Pearl Calloway | | | 2a. DATE KNOWN OF DEATH
MONTH 11 DAY 28 YEAR 84 | | 2b. HOUR 4:00 |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH 4 DAY 26 YEAR 14 | 6. AGE (IN YEARS)
LAST BIRTHDAY 70 YRS. | IF UNDER 1 YR.
MONTHS 0 DAYS 0 HOURS 0 MIN. 0 | IF UNDER 24 HRS.
MONTHS 0 DAYS 0 HOURS 0 MIN. 0 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
GA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
Garthersburg | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
746 Westside Drive | | 12a. USUAL OCCUPATION* (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | |
| 13a. STATE
Md. | | 13b. CITY OR TOWN
Garthersburg | | 13c. STREET ADDRESS
746 Westside Dr. | |
| 14. FATHER'S NAME
FIRST Moore MIDDLE Fisher LAST Fisher | | 15. MOTHER'S MAIDEN NAME
FIRST Stella MIDDLE Friend LAST Friend | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NOT OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
252-34-9756 | | 17. INFORMANT
Helen Woods (same as #13) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest.
DUE TO, OR AS A CONSEQUENCE OF
(b) Coronary arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).
Diabetes mellitus. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | |
| ACTUAL SIGNATURE
John Tauber | | TITLE (SPECIFY)
M.D. | | MEDICAL EXAMINER
Bethesda Md. | |
| EXAMINER'S NAME
(TYPE OR PRINT) John Tauber | | ADDRESS 8218 Wisconsin Ave | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
12-4-84 | | 23c. NAME OF CEMETERY OR CREMATORY
Harmony Mem Pk. | |
| 23d. LOCATION
CITY OR TOWN
Landoner | | COUNTY
Md. | | STATE | |
| 24. FUNERAL DIRECTOR
NAME
George R. Snowden | | ADDRESS
Rockville, Md. | | 25a. DATE REC'D. BY REGISTRAR
11-28-84 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
G. R. Snowden | |



No
Moore Fisher
Mr. Monte
Gatherburg the Westside Drive
Houswife
GA U.S.A
200-217-1011 (same as #13)
Stella Friend
the Westside Dr.

10-11-84



10-11-84
Mr. Monte
Gatherburg the Westside Drive
Houswife
GA U.S.A
200-217-1011 (same as #13)
Stella Friend
the Westside Dr.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH33911
REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | TIME HOUR MIN. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 12 7 84 | | 11 19 M | |
| 2b. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Female | | White | | MONTH DAY YEAR
Oct. 1, 1940 | | 44 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Wash., D.C. | | U.S.A. | | | | Mont. MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Takoma Park | | Washington Adventist | | Housewife | | - | |
| 13a. STATE | | 13b. CITY OR TOWN | | 13c. STREET ADDRESS / ZIP CODE | | (20783) | |
| Md. | | Pr. Geo. | | Adelphi | | 1801 - Metzgerott Rd. | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | No - | | 218-38-8167 | |
| William H. Ray | | Annie L. Smith | | 17. INFORMANT | | Address | |
| | | | | Mary L. Compton (Dtr.) | | College Pk. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 19. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| PART I. DEATH WAS CAUSED BY: | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| IMMEDIATE CAUSE (a) | | | | Cardiac Respiratory Arrest | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | (b) SEPSIS UREMIA | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | (c) multiple sclerosis | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | |
| AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/>
AT WORK <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | CITY OR TOWN STREET | | COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from | | 11-21- | | 19 84 | | to 12-6- 19 84 | |
| saw the deceased alive on | | 12-6- | | 19 84 | | and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | |
| Tony P. KANWARKA | | MD | | 12/7/84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| TONY P. KANWARKA T. MD | | 8201 16th St S.S. MD 20910 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Burial | | 12-10-84 | | Ft. Lincoln Cem. | | Brentwood Pr. Geo. Md. | |
| 24. FUNERAL DIRECTOR | | 25a. DATE RECD. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Nalley's F.H. Inc. Mt. Rainier, Md. | | DEC 1 2 1984 | | Julia Davidson-Randall | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 12 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| 1- STATE REGISTRAR | | | | | | | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 33912 | | | | | | | | | |
|---|--|---------|--|--|--|-------------------|--|--|--|---|--|--------------------------------------|--|----------|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | | | | | | | 2a. DATE KNOWN OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | |
| John W. Coombe | | | | | | | | | | X MONTH DAY YEAR
Dec. 20 19 84 | | | | | | | | | | 1:28 M | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | | | | | | | | | | | | | | | |
| Male | | White | | Nov. 10, 1894 | | 90 YRS. | | MONTHS | | DAYS | | Dec. 20, 19 84 | | 1:28 M | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | | | | | |
| Washington, D.C. | | | | U.S.A. | | | | | | | | Montgomery MD | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | |
| Takoma Park | | | | Washington Adventist Hospital | | | | Auto Salesman | | | | SteuartFord | | | | | | | | | | | | | | | | | |
| 13a. STATE | | | | | | | | | | 13b. COUNTY | | | | | | | | | | 13c. CITY OR TOWN | | | | | | | | | |
| Maryland | | | | | | | | | | Anne Arundel | | | | | | | | | | Edgewater | | | | | | | | | |
| 13d. INSIDE CITY LIMITS? | | | | | | | | | | 13e. STREET ADDRESS | | | | | | | | | | | | | | | | | | | |
| YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 3464 South River Terrace | | | | | | | | | | 21037 | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | |
| Harry Coombe | | | | | | | | | | Adelaide Christian Rudd | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | 17. INFORMANT | | | | | | | | | |
| No | | | | | | | | | | 578-07-6613 | | | | | | | | | | Mr. Douglas Coome-Son | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Asphyxiation | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) Airway obstruction | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) Large bolus of food | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| None | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? | | | | | | | | | |
| 12/19/84 | | | | | | | | | | Squamous cell carcinoma scalp | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | 21b. TIME OF INJURY | | | | | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| | | | | | | | | | | HOUR A.M. MONTH DAY YEAR
10:30 12 20 19 84 | | | | | | | | | | Choked on food | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | | | | | 21f. LOCATION | | | | | | | | | |
| | | | | | | | | | | Home | | | | | | | | | | Covell Ave Tak Park Murb Md | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | | | | | TITLE (SPECIFY) | | | | | | | | | | MEDICAL EXAMINER | | | | | | | | | |
| John S. Rogers, M.D. | | | | | | | | | | 1919 Seminary Rd. Sil. Spg. Md. 20910 | | | | | | | | | | DATE SIGNED Dec 22 1984 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | | | | | 23b. DATE | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | |
| Cremation | | | | | | | | | | Dec. 22, 1984 | | | | | | | | | | Ft. Lincoln Crematory | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| F. Gasch's Sons F.H. P.A. Hyattsville, Maryland | | | | | | | | | | DEC 24 1984 | | | | | | | | | | Julia Davidson-Randall | | | | | | | | | |

BP

| | | | | | | |
|------------------|-------------------------------|--------------|-----------------|--------|-------------|------|
| John | White | Nov. 7, 1881 | in | County | Dec. 20, 81 | 1:32 |
| Washington, D.C. | C.B.A. | X | Montgomery | | Dec. 20, 81 | 1:32 |
| Talbot Park | Washington Adventist Hospital | X | Auto Salesman | | Dec. 20, 81 | 1:32 |
| Indiana | and Wm. H. H. H. H. | X | Wm. H. H. H. H. | | Dec. 20, 81 | 1:32 |
| Conne | Wm. H. H. H. H. | X | Christian | | Dec. 20, 81 | 1:32 |
| to | Wm. H. H. H. H. | X | Wm. H. H. H. H. | | Dec. 20, 81 | 1:32 |

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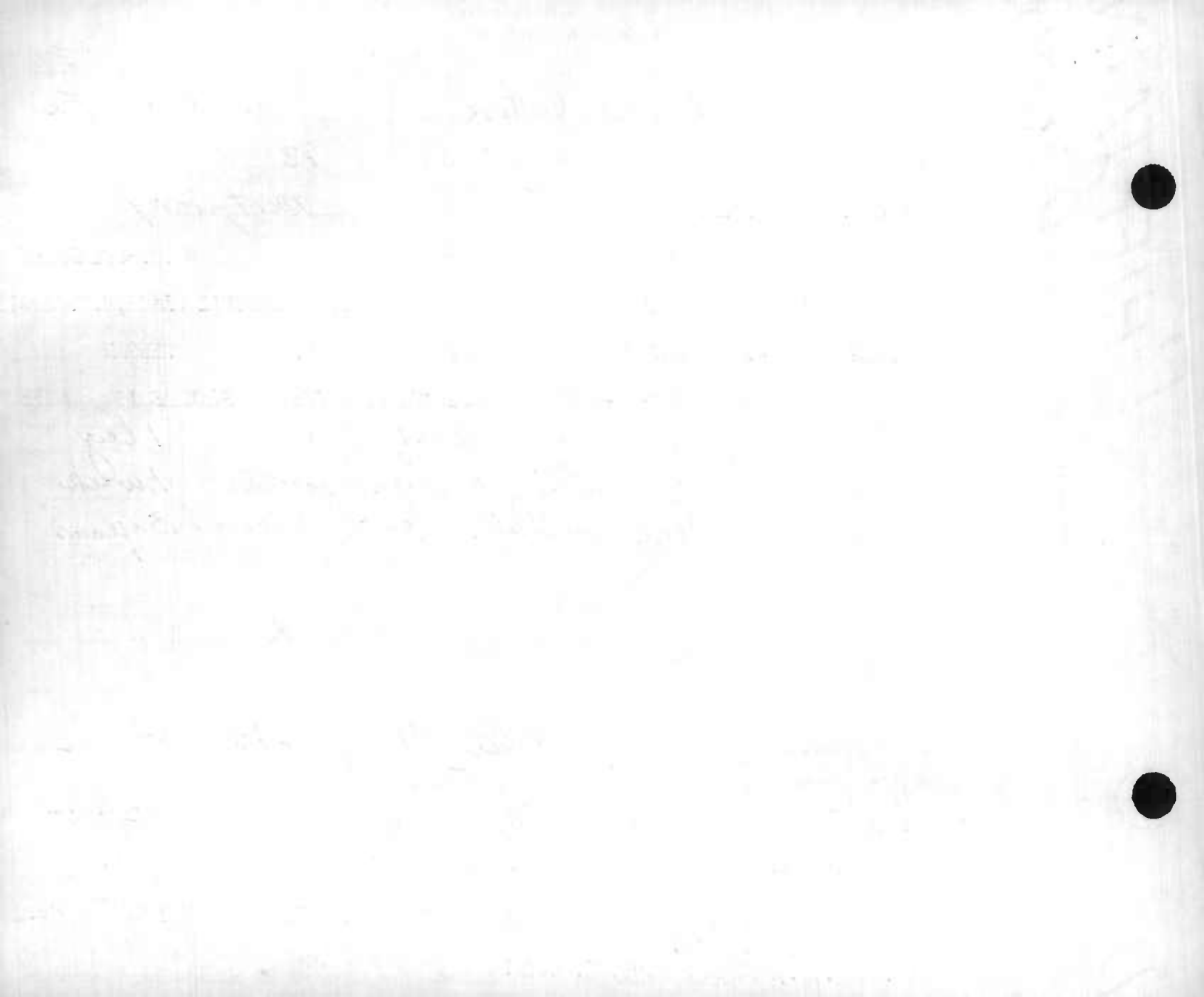
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

33913
REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Edward L Cotter</i> | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>12 8 84</i> | | 2b. HOUR
<i>1:30 a.m.</i> | |
| 3. SEX
<i>MALE</i> | | 4. RACE
<i>Cauc.</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>11 15 01</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>83</i> YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>WASHINGTON, D.C.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Suburban Hospital</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>U.S. GOVERNMENT</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
<i>N/A</i> | | 13b. COUNTY
<i>N/A</i> | | 13c. CITY OR TOWN
<i>WASHINGTON, DC</i> | | 13d. INSIDE CITY LIMITS?
<i>XX</i> YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>JOHN A. COTTER</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>MARY A. KEEGAN</i> | | 16. ADDRESS | | 17. STREET ADDRESS / ZIP CODE
<i>3274 ABERFOYLE PLACE, N.W. 20015</i> | |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
<i>NO</i> | | 18b. SOCIAL SECURITY NO.
<i>577-60-2753</i> | | 17. INFORMANT
<i>MARGUERITE C. COTTER</i> | | SAME AS 13 <i>WIFE</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line (a) or (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Intractable Heart Failure</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute Myocardial Infarction</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic Heart Disease</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>1 day</i>
<i>1 week</i>
<i>3 years</i> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 19c. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>19</i> | | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19: PART 1 OR PART 2) | | | |
| 20d. INJURY OCCURRED
WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 20f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 21. I certify that (I) <i>Blaine Fitzgerald</i> attended the deceased from <i>October 7/ 19 84</i> to <i>12/8 19 84</i> that (II) <i>me</i> last saw the deceased alive on <i>12/1 19 84</i> and that in my <i>me</i> opinion death occurred on the date and hour and from the causes stated above (I) <i>me</i> (b) <i>me</i> view the body after death. | | | | | | | |
| 22a. SIGNATURE
<i>Blaine Fitzgerald</i> | | 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>J. BLAINE FITZGERALD</i> | | 22c. ADDRESS
<i>SILVER SPRING MONT MD.</i> | | 22d. DATE SIGNED
<i>12/8/84</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (PRINT)
<i>BURIAL</i> | | 23b. DATE
<i>12/10/84</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>CEDAR HILL CEMETERY</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>SUITLAND PRI GEO MD.</i> | |
| 24. FUNERAL DIRECTOR
NAME <i>FRANCIS J. COLLINS</i> ADDRESS <i>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</i> | | | | 25. DATE REC'D BY REGISTRAR <i>DEC 13 1984</i> REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 33914
REG. NO. | |
|---|--|--|--|---|---|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Juleann S. COX | | | | | 2a. DATE OF DEATH MONTH 12 DAY 2 YEAR 84 | | | | 2b. HOUR 4:30 AM | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH 10 DAY 25 YEAR 39 | | 6. AGE (IN YEARS LAST BIRTHDAY) 45 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Office Manager | | | 12b. KIND OF BUSINESS OR INDUSTRY Doctor's Office | | |
| 13a. STATE MD | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Rockville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 4 Camden Ct. / 20850 | | | |
| 14. FATHER'S NAME FIRST Alex MIDDLE J. LAST Stutz | | | | | 15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Alice LAST Kyle | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 234-60-9390 | | 17. INFORMANT ADDRESS Mr. John W. Cox, Husband, Same as item #13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Brain metastases
DUE TO, OR AS A CONSEQUENCE OF (b) Breast Cancer
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 month
2 years | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a
Thrombocytopenia, Hypotension, Bone Metastases | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (i) (this hospital) attended the deceased from 12/1/84 to 12/2/84 , that (ii) (we) last saw the deceased alive on 12/1/84 , and that in (my/our) opinion death occurred on the date and hour and from the causes stated. | | | | | | | | | | | |
| 22b. SIGNATURE Peter Sherer | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 12/2/84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Peter Sherer | | | | 22e. ADDRESS 3947 Ferrara Dr. Wheaton MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | | 23b. DATE December 2, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia | | | |
| 24. FUNERAL DIRECTOR NAME Robert A. Pumphrey | | | | ADDRESS Funeral Homes, P.A., Rockville, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR DEC 5 1984 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

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12 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
100 95 90 85 80 75 70 65 60 55 50 45 40 35 30 25 20 15 10 5 0
100 95 90 85 80 75 70 65 60 55 50 45 40 35 30 25 20 15 10 5 0

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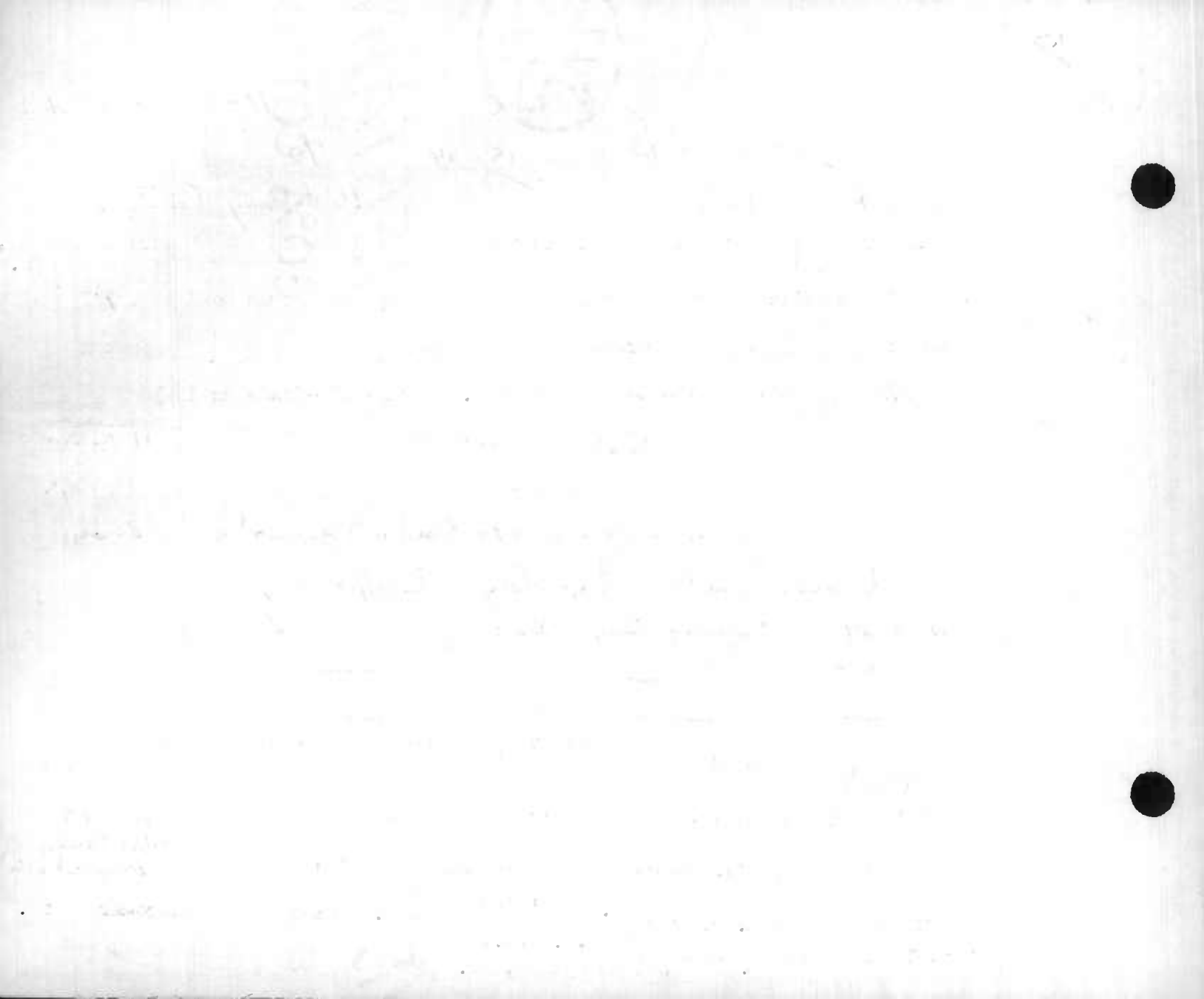
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION


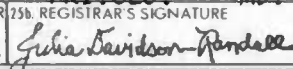
| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | 33915
REG. NO. | |
|---|--|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) McGill Owen CRAVER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-31-84 | | 7b. HOUR
2:00 A.M. | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
11-19-14 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
U.S.A. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Salesman | | 12b. KIND OF BUSINESS OR INDUSTRY
Sears & Roebuck, Co. |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY Prince Georges 13c. CITY OR TOWN Laurel | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
10624 Gorman Road 20707 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Winfield Craver | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ethel Easton | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
N/A | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | | 17. INFORMANT ADDRESS
Jane H. Craver-wife-(same as 13e) | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sepsis Shwcho
DUE TO, OR AS A CONSEQUENCE OF (b) Renal Failure
DUE TO, OR AS A CONSEQUENCE OF (c) 12-10-84 & 12-11-84 Cardiac Tamponade
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 hours
20 days
20 days | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
Pneumonia with Respiratory Insufficiency | | | | | | |
| 19a. DATE OF OPERATION
12-10-84 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Coronary Artery Disease | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-9- 19 84 to 12-31- 19 84 , that (I) (we) last saw the deceased alive on 12-30- 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Dr. J. R. Davidson KIEHLER, MD | | DEGREE
MD | | 22c. DATE SIGNED
12-31-84 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. J. R. Davidson KIEHLER, MD | | 22e. ADDRESS
Suite 29 St. John's University Boulevard East Silver Spring, Maryland 20910 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Jan. 3, 1985 | | 23c. NAME OF CEMETERY OR CREMATOR
St. John's Church Cem. | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Olney Montgomery Md. | | 23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE
JAN 3 1985 J. R. Davidson-Kendall | | | | |
| 24. FUNERAL DIRECTOR
Hines/Rinaldi Funeral Home | | 25. ADDRESS
11800 N.H. Ave., Silver Spring, Md. | | | | |



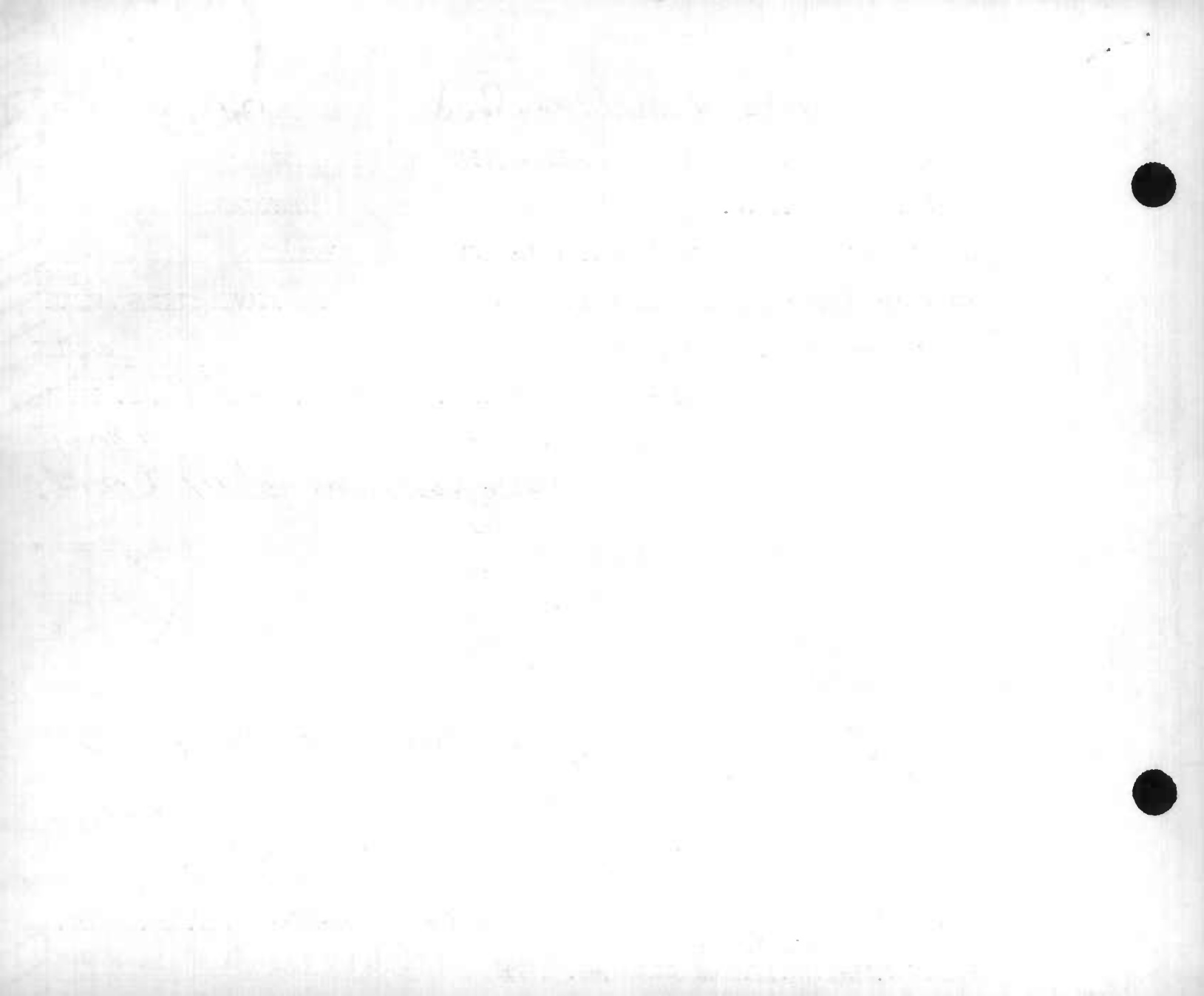
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 33916
REG. NO. | |
|--|--|---|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Celeste V. VIRGINIA Crawford | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/12/84 | | | 2b. HOUR
11³⁰ P M | | | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
JULY 24, 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS. | | 7. UNDER 1 YEAR
MONTHS DAYS | | 8. UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
TAKOMA PARK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
WASHINGTON ADVENTIST HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
MARYLAND | | | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
GEORGE A. SHELTON | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ELSIE BURRIER | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | | 16b. SOCIAL SECURITY NO.
220-44-1705 | | 17. INFORMANT
BROTHER ADDRESS
129 E 6TH STREET
ALVEY E. SHELTON, SR. FREDERICK, MD. 21701 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Lactic Acidosis | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Colon Carcinoma to liver | | | | | | | | | | 2 months | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from 10 Dec 1984 to 11 Dec 1984 , that (we) last saw the deceased alive on 11 Dec 1984 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
 | | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
13 Dec 84 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Michael Leibman | | | | | 22e. ADDRESS
111 W. N. H. ST., MD 20904 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
12/15/84 | | 23c. NAME OF CEMETERY OR CREMATORY
GEORGE WASHINGTON | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ADELPHI PRI GEO. MD. | | | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 17 1984 | | 25b. REGISTRAR'S SIGNATURE
 | | | | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by letter.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 33917 | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
NORRIENE MARIE CRIST | | | | 2a. DATE OF DEATH
Dec. 22, '84 | | 2b. HOUR
1:00 a.m. | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
SEPT. 17, 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY)
91 YRS | | 7. UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY CO. MD. | | | |
| 10. CITY OR TOWN OF DEATH
ROCKVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NATIONAL LUTHERAN HOME | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
CLERK | | 12b. KIND OF BUSINESS OR INDUSTRY
NOT AVAILABLE | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
333- HARLEM AVENUE 21222 | |
| 14. FATHER'S NAME
JOSEPH W. CRIST | | | | 15. MOTHER'S MAIDEN NAME
NELLIE EDGAR DEMITZ | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
215-07-1192 | | 17. INFORMANT ADDRESS
REV. DR. RICHARD REICHARD- NLH - ROCKVILLE, MD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ASPIRATION PNEUMONIA</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Advanced Alzheimer's disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MONTH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>OCT. 26,</u> 19 <u>72</u> , to <u>DEC. 22</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>DEC. 22,</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Thomas E. Doolley, MD</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12-22-84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
THOMAS E. DOOLEY, MD | | | | 22e. ADDRESS
17904 GEORGE A AVENUE
OLNEY, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
DEC. 26, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
LOUDON PARK CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE, MARYLAND | | | |
| 24. FUNERAL DIRECTOR
NAME
HYSONG CO., INC-1300- N ST., NW WASH., DC | | | | 24. RECEIVED BY
NAME
JUL 31 1984 J. L. Doolley, Jr. | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

33918
REG. NO.

| | | | | | | | | | | | | | |
|--|--|--|--|---|---------------|---|--|--|--|--|-----------|--|----------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
Charles | | MIDDLE
I. | LAST
Cross | 2a. DATE OF DEATH | | | | MONTH
Dec | DAY
18 | YEAR
'84 | 2b. HOUR
530 P.M. |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 8, 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE
(COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Wheaton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF IN STATE, CITY, COUNTY, OR STREET ADDRESS)
Randolph Hills Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Dairyman | | 12b. KIND OF BUSINESS OR INDUSTRY
Dairy | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3 Cleveland Court 20850 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Herman Cross | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Clara Brandy | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no | | 16b. SOCIAL SECURITY NO.
105 01 4482 | | 17. INFORMANT
ADDRESS
Roy E. Fordham same as 13e | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>End stage Parkinson's disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Aspiration Pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Aspiration Pneumonia</u> | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)
<u>Dehydration</u> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1</u> , 19 <u>84</u> , to <u>Dec. 18</u> , 19 <u>84</u> , that (I) (we) lost
saw the deceased alive on <u>Nov. 21</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>K.S. Kim</u> | | | | DEGREE
M.D. | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12/18/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
KWANG S. KIM | | | | 22e. ADDRESS
11119 Rockville Pike, Rockville, MD 20850 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
12/22/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Oakwood Cemetery | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Syracuse, New York | | | |
| 24. FUNERAL DIRECTOR
Tyson Wheeler Funeral Home, Inc.
1331 Rockville Pike, Rockville, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 24 1984 | | 25b. REGISTRAR'S SIGNATURE
<u>Luke Davidson</u> | | | | | |

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|---|--|---|---|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
John Asa Croteau JR. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/02/84 | | | 2b. HOUR
06:40pm | | | | |
| 3. SEX
Male | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
12/02/26 | | 6. AGE (IN YEARS LAST BIRTHDAY)
58 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW HAMPSHIRE | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
ELEC. TECH | | 12b. KIND OF BUSINESS OR INDUSTRY
EROLS, INS. | | |
| 13a. STATE
MARYLAND | | | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
ROCKVILLE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOHN ASA CROTEAU, SR. | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ALICE CURRIER | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
003-14-8823 | | 17. INFORMANT
ADDRESS
BETTY R. CROTEAU SAME AS 13 WIFE | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ruptured Abdominal Aortic Aneurysm
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 hrs. | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Fatty metamorphosis Liver | | | | | | | | | | |
| 19a. DATE OF OPERATION
12/2/84 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Abd. Aortic Aneurysm | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/2 , 19 84 , to 12/2 , 19 84 , that (I) (we) lost
saw the deceased alive on 12/2 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Robert L. Fox | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12/3/84 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert L. Fox M.D. | | | | 22e. ADDRESS
18111 Prince Phillip Dr. Olney, M.D. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12/7/84 | | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | | | 23d. LOCATION
(CITY OR TOWN) COUNTY STATE
SILVER SPRING MONT MD. | | | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS
ADDRESS
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 6 1984 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the certificate should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

12/17/84
J. COLLINS
DATE OF BIRTH



12/17/84

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

33920
REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | |
|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Stella C. Cullen | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 6, 1984 | | 2b. HOUR
1:35p M |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 30, 1885 | | 6. AGE (IN YEARS LAST BIRTHDAY)
99 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington D.C. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Carriage Hill Nursing Home | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
School Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY
Phila. Pub. Sch |
| 13a. STATE
None | 13b. COUNTY
None | 13c. CITY OR TOWN
Washington DC | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
5420 Conn. Ave. N.W. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James F. Cullen | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary J. Thompson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | | 17. INFORMANT
ADDRESS
Dorothy M. Cullen (Niece) 119 Primrose St. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for each day, and)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart disease
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from 12/5 19 83 to 12/6 19 84 , that (I) (we) lost the deceased alive on 12/5 19 84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death) | | | | | |
| 22b. SIGNATURE
J. Blaine Fitzgerald, M. D. | | 22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22d. DATE SIGNED
December 6, 1984 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Dec. 10, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Olivet Cemetery | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington D.C. | | 23e. REGISTRAR'S SIGNATURE
DEC 8 1984 | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
DeVol Funeral Home
2222 Wisconsin Avenue, NW, Washington, DC 20007 | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Stella

Gillen

December 6, 1984

Female

Caucasian

Oct. 20, 1981

Montgomery

Washington, D.C. USA

Bethesda

Carrigoe Hill Nursing Home

3830 Conn. Ave. N.W.

Washington, D.C.

Zone 1

1. Thompson

Zone 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12

NO. 1-2-3-4-5-6-7-8-9-10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100-101-102-103-104-105-106-107-108-109-110-111-112-113-114-115-116-117-118-119-120-121-122-123-124-125-126-127-128-129-130-131-132-133-134-135-136-137-138-139-140-141-142-143-144-145-146-147-148-149-150-151-152-153-154-155-156-157-158-159-160-161-162-163-164-165-166-167-168-169-170-171-172-173-174-175-176-177-178-179-180-181-182-183-184-185-186-187-188-189-190-191-192-193-194-195-196-197-198-199-200-201-202-203-204-205-206-207-208-209-210-211-212-213-214-215-216-217-218-219-220-221-222-223-224-225-226-227-228-229-230-231-232-233-234-235-236-237-238-239-240-241-242-243-244-245-246-247-248-249-250-251-252-253-254-255-256-257-258-259-260-261-262-263-264-265-266-267-268-269-270-271-272-273-274-275-276-277-278-279-280-281-282-283-284-285-286-287-288-289-290-291-292-293-294-295-296-297-298-299-300-301-302-303-304-305-306-307-308-309-310-311-312-313-314-315-316-317-318-319-320-321-322-323-324-325-326-327-328-329-330-331-332-333-334-335-336-337-338-339-340-341-342-343-344-345-346-347-348-349-350-351-352-353-354-355-356-357-358-359-360-361-362-363-364-365-366-367-368-369-370-371-372-373-374-375-376-377-378-379-380-381-382-383-384-385-386-387-388-389-390-391-392-393-394-395-396-397-398-399-400-401-402-403-404-405-406-407-408-409-410-411-412-413-414-415-416-417-418-419-420-421-422-423-424-425-426-427-428-429-430-431-432-433-434-435-436-437-438-439-440-441-442-443-444-445-446-447-448-449-450-451-452-453-454-455-456-457-458-459-460-461-462-463-464-465-466-467-468-469-470-471-472-473-474-475-476-477-478-479-480-481-482-483-484-485-486-487-488-489-490-491-492-493-494-495-496-497-498-499-500-501-502-503-504-505-506-507-508-509-510-511-512-513-514-515-516-517-518-519-520-521-522-523-524-525-526-527-528-529-530-531-532-533-534-535-536-537-538-539-540-541-542-543-544-545-546-547-548-549-550-551-552-553-554-555-556-557-558-559-560-561-562-563-564-565-566-567-568-569-570-571-572-573-574-575-576-577-578-579-580-581-582-583-584-585-586-587-588-589-590-591-592-593-594-595-596-597-598-599-600-601-602-603-604-605-606-607-608-609-610-611-612-613-614-615-616-617-618-619-620-621-622-623-624-625-626-627-628-629-630-631-632-633-634-635-636-637-638-639-640-641-642-643-644-645-646-647-648-649-650-651-652-653-654-655-656-657-658-659-660-661-662-663-664-665-666-667-668-669-670-671-672-673-674-675-676-677-678-679-680-681-682-683-684-685-686-687-688-689-690-691-692-693-694-695-696-697-698-699-700-701-702-703-704-705-706-707-708-709-710-711-712-713-714-715-716-717-718-719-720-721-722-723-724-725-726-727-728-729-730-731-732-733-734-735-736-737-738-739-740-741-742-743-744-745-746-747-748-749-750-751-752-753-754-755-756-757-758-759-760-761-762-763-764-765-766-767-768-769-770-771-772-773-774-775-776-777-778-779-780-781-782-783-784-785-786-787-788-789-790-791-792-793-794-795-796-797-798-799-800-801-802-803-804-805-806-807-808-809-810-811-812-813-814-815-816-817-818-819-820-821-822-823-824-825-826-827-828-829-830-831-832-833-834-835-836-837-838-839-840-841-842-843-844-845-846-847-848-849-850-851-852-853-854-855-856-857-858-859-860-861-862-863-864-865-866-867-868-869-870-871-872-873-874-875-876-877-878-879-880-881-882-883-884-885-886-887-888-889-890-891-892-893-894-895-896-897-898-899-900-901-902-903-904-905-906-907-908-909-910-911-912-913-914-915-916-917-918-919-920-921-922-923-924-925-926-927-928-929-930-931-932-933-934-935-936-937-938-939-940-941-942-943-944-945-946-947-948-949-950-951-952-953-954-955-956-957-958-959-960-961-962-963-964-965-966-967-968-969-970-971-972-973-974-975-976-977-978-979-980-981-982-983-984-985-986-987-988-989-990-991-992-993-994-995-996-997-998-999-1000-1001-1002-1003-1004-1005-1006-1007-1008-1009-1010-1011-1012-1013-1014-1015-1016-1017-1018-1019-1020-1021-1022-1023-1024-1025-1026-1027-1028-1029-1030-1031-1032-1033-1034-1035-1036-1037-1038-1039-1040-1041-1042-1043-1044-1045-1046-1047-1048-1049-1050-1051-1052-1053-1054-1055-1056-1057-1058-1059-1060-1061-1062-1063-1064-1065-1066-1067-1068-1069-1070-1071-1072-1073-1074-1075-1076-1077-1078-1079-1080-1081-1082-1083-1084-1085-1086-1087-1088-1089-1090-1091-1092-1093-1094-1095-1096-1097-1098-1099-1100-1101-1102-1103-1104-1105-1106-1107-1108-1109-1110-1111-1112-1113-1114-1115-1116-1117-1118-1119-1120-1121-1122-1123-1124-1125-1126-1127-1128-1129-1130-1131-1132-1133-1134-1135-1136-1137-1138-1139-1140-1141-1142-1143-1144-1145-1146-1147-1148-1149-1150-1151-1152-1153-1154-1155-1156-1157-1158-1159-1160-1161-1162-1163-1164-1165-1166-1167-1168-1169-1170-1171-1172-1173-1174-1175-1176-1177-1178-1179-1180-1181-1182-1183-1184-1185-1186-1187-1188-1189-1190-1191-1192-1193-1194-1195-1196-1197-1198-1199-1200-1201-1202-1203-1204-1205-1206-1207-1208-1209-1210-1211-1212-1213-1214-1215-1216-1217-1218-1219-1220-1221-1222-1223-1224-1225-1226-1227-1228-1229-1230-1231-1232-1233-1234-1235-1236-1237-1238-1239-1240-1241-1242-1243-1244-1245-1246-1247-1248-1249-1250-1251-1252-1253-1254-1255-1256-1257-1258-1259-1260-1261-1262-1263-1264-1265-1266-1267-1268-1269-1270-1271-1272-1273-1274-1275-1276-1277-1278-1279-1280-1281-1282-1283-1284-1285-1286-1287-1288-1289-1290-1291-1292-1293-1294-1295-1296-1297-1298-1299-1300-1301-1302-1303-1304-1305-1306-1307-1308-1309-1310-1311-1312-1313-1314-1315-1316-1317-1318-1319-1320-1321-1322-1323-1324-1325-1326-1327-1328-1329-1330-1331-1332-1333-1334-1335-1336-1337-1338-1339-1340-1341-1342-1343-1344-1345-1346-1347-1348-1349-1350-1351-1352-1353-1354-1355-1356-1357-1358-1359-1360-1361-1362-1363-1364-1365-1366-1367-1368-1369-1370-1371-1372-1373-1374-1375-1376-1377-1378-1379-1380-1381-1382-1383-1384-1385-1386-1387-1388-1389-1390-1391-1392-1393-1394-1395-1396-1397-1398-1399-1400-1401-1402-1403-1404-1405-1406-1407-1408-1409-1410-1411-1412-1413-1414-1415-1416-1417-1418-1419-1420-1421-1422-1423-1424-1425-1426-1427-1428-1429-1430-1431-1432-1433-1434-1435-1436-1437-1438-1439-1440-1441-1442-1443-1444-1445-1446-1447-1448-1449-1450-1451-1452-1453-1454-1455-1456-1457-1458-1459-1460-1461-1462-1463-1464-1465-1466-1467-1468-1469-1470-1471-1472-1473-1474-1475-1476-1477-1478-1479-1480-1481-1482-1483-1484-1485-1486-1487-1488-1489-1490-1491-1492-1493-1494-1495-1496-1497-1498-1499-1500-1501-1502-1503-1504-1505-1506-1507-1508-1509-1510-1511-1512-1513-1514-1515-1516-1517-1518-1519-1520-1521-1522-1523-1524-1525-1526-1527-1528-1529-1530-1531-1532-1533-1534-1535-1536-1537-1538-1539-1540-1541-1542-1543-1544-1545-1546-1547-1548-1549-1550-1551-1552-1553-1554-1555-1556-1557-1558-1559-1560-1561-1562-1563-1564-1565-1566-1567-1568-1569-1570-1571-1572-1573-1574-1575-1576-1577-1578-1579-1580-1581-1582-1583-1584-1585-1586-1587-1588-1589-1590-1591-1592-1593-1594-1595-1596-1597-1598-1599-1600-1601-1602-1603-1604-1605-1606-1607-1608-1609-1610-1611-1612-1613-1614-1615-1616-1617-1618-1619-1620-1621-1622-1623-1624-1625-1626-1627-1628-1629-1630-1631-1632-1633-1634-1635-1636-1637-1638-1639-1640-1641-1642-1643-1644-1645-1646-1647-1648-1649-1650-1651-1652-1653-1654-1655-1656-1657-1658-1659-1660-1661-1662-1663-1664-1665-1666-1667-1668-1669-1670-1671-1672-1673-1674-1675-1676-1677-1678-1679-1680-1681-1682-1683-1684-1685-1686-1687-1688-1689-1690-1691-1692-1693-1694-1695-1696-1697-1698-1699-1700-1701-1702-1703-1704-1705-1706-1707-1708-1709-1710-1711-1712-1713-1714-1715-1716-1717-1718-1719-1720-1721-1722-1723-1724-1725-1726-1727-1728-1729-1730-1731-1732-1733-1734-1735-1736-1737-1738-1739-1740-1741-1742-1743-1744-1745-1746-1747-1748-1749-1750-1751-1752-1753-1754-1755-1756-1757-1758-1759-1760-1761-1762-1763-1764-1765-1766-1767-1768-1769-1770-1771-1772-1773-1774-1775-1776-1777-1778-1779-1780-1781-1782-1783-1784-1785-1786-1787-1788-1789-1790-1791-1792-1793-1794-1795-1796-1797-1798-1799-1800-1801-1802-1803-1804-1805-1806-1807-1808-1809-1810-1811-1812-1813-1814-1815-1816-1817-1818-1819-1820-1821-1822-1823-1824-1825-1826-1827-1828-1829-1830-1831-1832-1833-1834-1835-1836-1837-1838-1839-1840-1841-1842-1843-1844-1845-1846-1847-1848-1849-1850-1851-1852-1853-1854-1855-1856-1857-1858-1859-1860-1861-1862-1863-1864-1865-1866-1867-1868-1869-1870-1871-1872-1873-1874-1875-1876-1877-1878-1879-1880-1881-1882-1883-1884-1885-1886-1887-1888-1889-1890-1891-1892-1893-1894-1895-1896-1897-1898-1899-1900-1901-1902-1903-1904-1905-1906-1907-1908-1909-1910-1911-1912-1913-1914-1915-1916-1917-1918-1919-1920-1921-1922-1923-1924-1925-1926-1927-1928-1929-1930-1931-1932-1933-1934-1935-1936-1937-1938-1939-1940-1941-1942-1943-1944-1945-1946-1947-1948-1949-1950-1951-1952-1953-1954-1955-1956-1957-1958-1959-1960-1961-1962-1963-1964-1965-1966-1967-1968-1969-1970-1971-1972-1973-1974-1975-1976-1977-1978-1979-1980-1981-1982-1983-1984-1985-1986-1987-1988-1989-1990-1991-1992-1993-1994-1995-1996-1997-1998-1999-2000-2001-2002-2003-2004-2005-2006-2007-2008-2009-2010-2011-2012-2013-2014-2015-2016-2017-2018-2019-2020-2021-2022-2023-2024-2025-2026-2027-2028-2029-2030-2031-2032-2033-2034-2035-2036-2037-2038-2039-2040-2041-2042-2043-2044-2045-2046-2047-2048-2049-2050-2051-2052-2053-2054-2055-2056-2057-2058-2059-2060-2061-2062-2063-2064-2065-2066-2067-2068-2069-2070-2071-2072-2073-2074-2075-2076-2077-2078-2079-2080-2081-2082-2083-2084-2085-2086-2087-2088-2089-2090-2091-2092-2093-2094-2095-2096-2097-2098-2099-2100-2101-2102-2103-2104-2105-2106-2107-2108-2109-2110-2111-2112-2113-2114-2115-2116-2117-2118-2119-2120-2121-2122-2123-2124-2125-2126-2127-2128-2129-2130-2131-2132-2133-2134-2135-2136-2137-2138-2139-2140-2141-2142-2143-2144-2145-2146-2147-2148-2149-2150-2151-2152-2153-2154-2155-2156-2157-2158-2159-2160-2161-2162-2163-2164-2165-2166-2167-2168-2169-2170-2171-2172-2173-2174-2175-2176-2177-2178-2179-2180-2181-2182-2183-2184-2185-2186-2187-2188-2189-2190-2191-2192-2193-2194-2195-2196-2197-2198-2199-2200-2201-2202-2203-2204-2205-2206-2207-2208-2209-2210-2211-2212-2213-2214-2215-2216-2217-2218-2219-2220-2221-2222-2223-2224-2225-2226-2227-2228-2229-2230-2231-2232-2233-2234-2235-2236-2237-2238-2239-2240-2241-2242-2243-2244-2245-2246-2247-2248-2249-2250-2251-2252-2253-2254-2255-2256-2257-2258-2259-2260-2261-2262-2263-2264-2265-2266-2267-2268-2269-2270-2271-2272-2273-2274-2275-2276-2277-2278-2279-2280-2281-2282-2283-2284-2285-2286-2287-2288-2289-2290-2291-2292-2293-2294-2295-2296-2297-2298-2299-2300-2301-2302-2303-2304-2305-2306-2307-2308-2309-2310-2311-2312-2313-2314-2315-2316-2317-2318-2319-2320-2321-2322-2323-2324-2325-2326-2327-2328-2329-2330-2331-2332-2333-2334-2335-2336-2337-2338-2339-2340-2341-2342-2343-2344-2345-2346-2347-2348-2349-2350-2351-2352-2353-2354-2355-2356-2357-2358-2359-2360-2361-2362-2363-2364-2365-2366-2367-2368-2369-2370-2371-2372-2373-2374-2375-2376-2377-2378-2379-2380-2381-2382-2383-2384-2385-2386-2387-2388-2389-2390-2391-2392-2393-2394-2395-2396-2397-2398-2399-2400-2401-2402-2403-2404-2405-2406-2407-2408-2409-2410-2411-2412-2413-2414-2415-2416-2417-2418-2419-2420-2421-2422-2423-2424-2425-2426-2427-2428-2429-2430-2431-2432-2433-2434-2435-2436-2437-2438-2439-2440-2441-2442-2443-2444-2445-2446-2447-2448-2449-2450-2451-2452-2453-2454-2455-2456-2457-2458-2459-2460-2461-2462-2463-2464-2465-2466-2467-2468-2469-2470-2471-2472-2473-2474-2475-2476-2477-2478-2479-2480-2481-2482-2483-2484-2485-2486-2487-2488-2489-2490-2491-2492-2493-2494-2495-2496-2497-2498-2499-2500-2501-2502-2503-2504-2505-2506-2507-2508-2509-2510-2511-2512-2513-2514-2515-2516-2517-2518-2519-2520-2521-2522-2523-2524-2525-2526-2527-2528-2529-2530-2531-2532-2533-2534-2535-2536-2537-2538-2539-2540-2541-2542-2543-2544-2545-2546-2547-2548-2549-2550-2551-2552-2553-2554-2555-2556-2557-2558-2559-2560-2561-2562-2563-2564-2565-2566-

GEY

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 50M 4/83
(VRA 15, 4)1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH33921
REG. NO.

| | | | | | | | | | | |
|---|--|--|---|---|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ROGER (NMN) CURRY | | | 2a. DATE OF DEATH MONTH DAY YEAR
DECEMBER 8, 1984 | | | 2b. HOUR
11:00 P_M | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
JANUARY 27, 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New Hampshire | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY, MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NIH, THE CLINICAL CENTER | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Owner | | 12b. KIND OF BUSINESS OR
Insurance Agency | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
INDIANA | | | 13b. COUNTY
Monroe | | 13c. CITY OR TOWN
BLOOMINGTON | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
927 S. JORDAN AVENUE 47401 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Berton E. Curry | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anne Coe | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | 16b. SOCIAL SECURITY NO.
WWII 304 12 0266 | | 17. INFORMANT
CAROL S. CURRY, WIFE | | | | ADDRESS
SAME AS PT. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary arrest | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
minutes | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <div style="display: inline-block; vertical-align: middle; font-size: 3em; margin: 0 10px;">}</div> DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic esophageal cancer
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | weeks | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a. | | | | | | | | | | |
| 19a. DATE OF OPERATION
10/22/84 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Large squamous cell carcinoma of esophagus | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 3, 1984 to December 8, 1984 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on DECEMBER 8, 1984 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Brent Treiger | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
12.9.84 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Brent Treiger | | | 22e. ADDRESS
NATIONAL INSTITUTES OF HEALTH
BETHESDA, MARYLAND 20205 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
Dec 12, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Valhalla Memory Gardens | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Bloomington Indiana | | | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland 20814 | | | 25a. DATE REC'D. BY REGISTRAR
DEC 11 1984 | | 25b. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | | | |

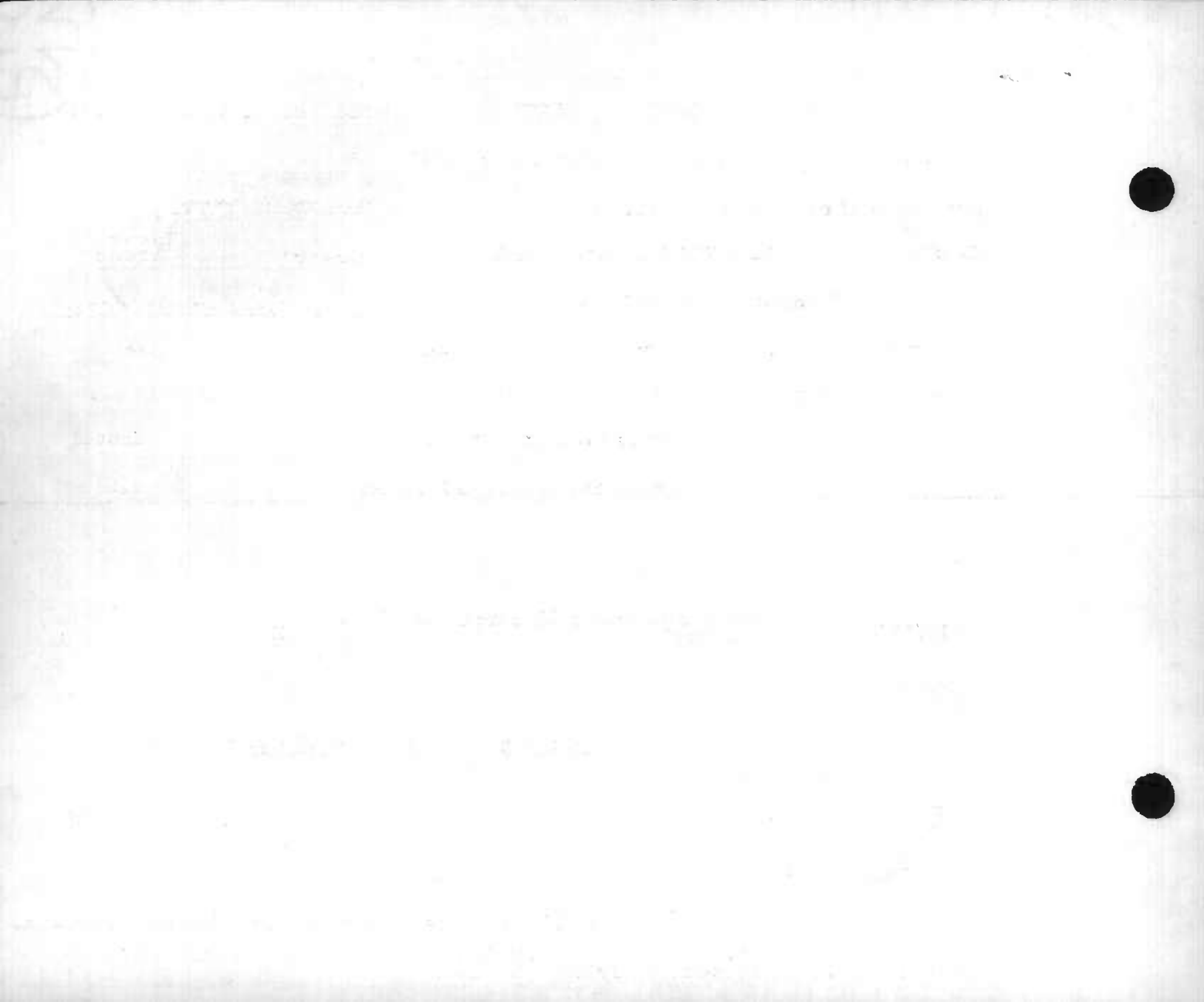
MEDICAL CERTIFICATION

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 3 3 9 2 2
REG. NO. | | | |
|---|--|--|--|--|--|--|---|---------------------------------|---|---|------------------------|-----------------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 7b. HOUR | | |
| | | | | | James B. CUSICK | | Dec. 21, 1984 | | | | 4:30A M | | |
| 3. SEX | | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | 7c. IF UNDER 1 YEAR | | |
| Male | | | White | | Aug. 13, 1903 | | | 81 YRS | | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| New York | | | U.S.A. | | | | | | Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Oney | | | Montgomery General Hospital | | | | | | | Store Owner | | | |
| 13a. STATE | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | |
| New York | | | | | Kings | | Brooklyn | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 37 Sherman St., 11215 | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| James H. Cusick | | | | | Mary Ann O'Sullivan | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | | |
| No | | | | | 066-01-9165 | | Rita Mulgrew, 25628 Ridge Rd. Damascus, Md. 20872 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE (a) Cerebrovascular Accident | | | | | | | | | | day 5 | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | |
| Chronic Obstructive Pulmonary Disease | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION | | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from December 18, 1984, to December 21, 1984, that (1) (two) lost soul the deceased alive on December 20, 1984, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (1) (two) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | | | | 22c. DATE SIGNED | | | |
| Barry Hecks M.D. | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | December 21, 1984 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | | | | | |
| BARRY HECKS | | | | | 10620 GEORGIN AVENUE SILVER SPRING MD | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | | | | |
| Burial | | | Dec. 27, 1984 | | Holy Cross | | | CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | Brooklyn, New York | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | | 25b. REGISTRAR'S SIGNATURE | |
| Olin L. Molesworth, P.A., Damascus, Md. 20872 | | | | | | DEC 27 1984 | | | | | | John Davidson-Rodell | |

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Dec. 21, 1934

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Dec. 13, 1903

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U.S.A.

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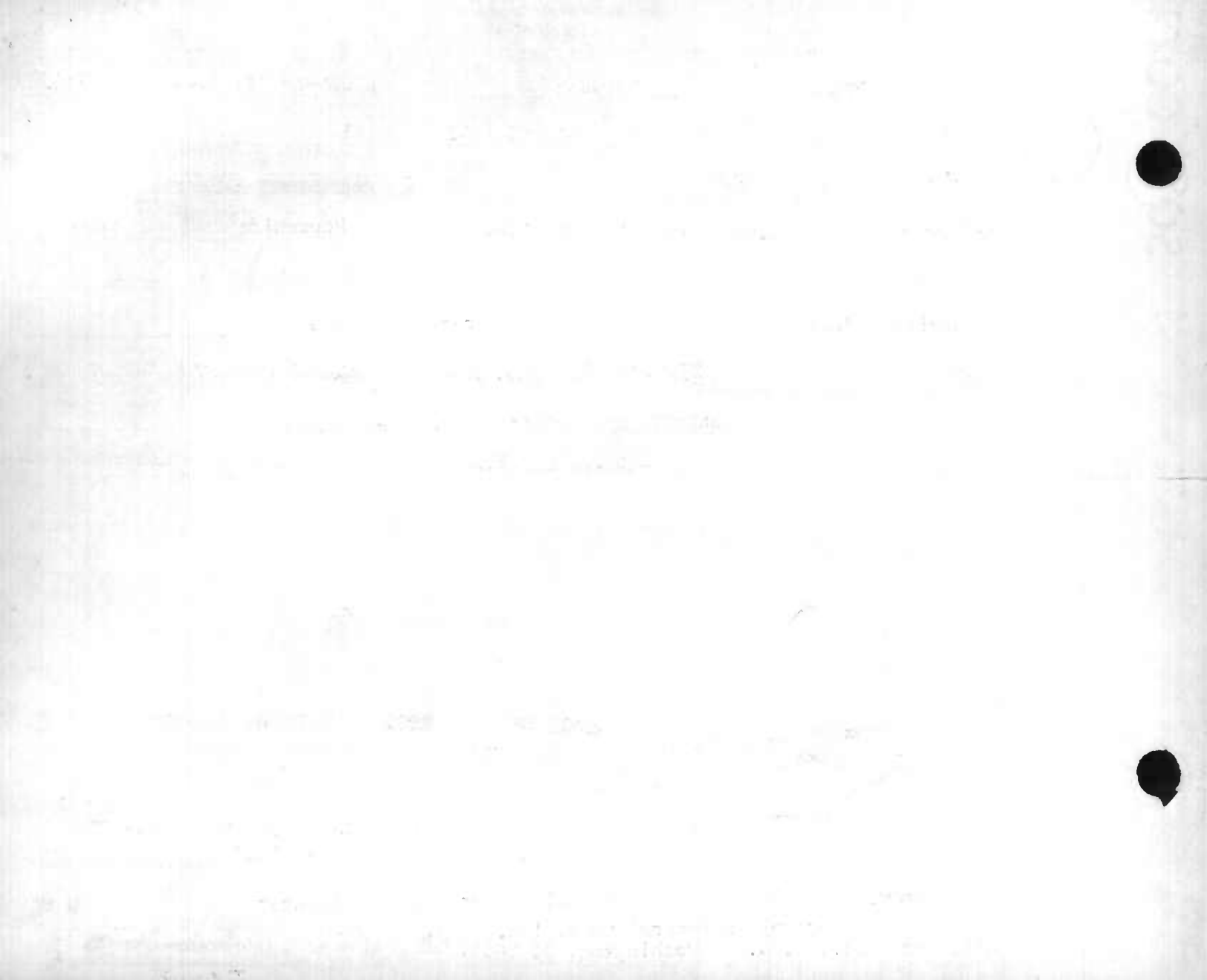
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR
STATE
REGISTRAR | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 3 3 9 2 3
REG. NO. | | | |
|---|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FRANCES KAY DAUGHERTY | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 31, 1984 | | | | 2b. HOUR
7:45A | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
JULY 06, 1943 | | 6. AGE (IN YEARS LAST BIRTHDAY)
41 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ohio | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
CLINICAL CENTER, NIH BETH. MD | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
None | | | |
| 13a. STATE
SPENCER | | | | 13b. CITY OR TOWN
WEST VIRGINIA | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE
259 CHAPMAN AVE 25276 | | 99999 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Orville Wine | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Irene Wine | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES
no | | | | 16b. SOCIAL SECURITY NO.
235-68-6195 | | 17. INFORMANT ADDRESS
MRS. STEPHANIE MATICS (DAUGHTER) REEDY, WV | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST BY CLINICAL HISTORY</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>HODGKIN'S DISEASE</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>MARCH 18</u> , 19 <u>1981</u> , to <u>DECEMBER 31</u> , 19 <u>84</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>DECEMBER 31</u> , 19 <u>84</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Salvatore Jones</i> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | DATE SIGNED
1/1/85 | | | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Salvatore Jones</i> | | | | 22d. ADDRESS
NATIONAL INSTITUTES OF HEALTH
CLINICAL CENTER, BETHESDA, MD 20205 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | | | 23b. DATE
1-2-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Vandale Funeral Home | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Spencer W. VA | | | |
| 24. FUNERAL DIRECTOR
NAME
Marshall's Funeral Home, Inc.
4217 9th St., N. W. Washington, DC 20011 | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 7 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 33924
REG. NO. | | | | | |
|--|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Martin A. Daugherty | | | | 2a. DATE OF DEATH MONTH DAY YEAR
December 27 1984 | | | | 2b. HOUR
M | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
March 15, 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
64 | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Gaithersburg | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
8 Duvall Lane | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Personnel Manager | | 12b. KIND OF BUSINESS OR INDUSTRY
Nuclear Reg. Comm. | | | |
| 13a. STATE
Md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
8 Duvall Lane 20877 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Martin A. Daugherty | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Margaretta Craig | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes WWII | | 16b. SOCIAL SECURITY NO.
159-14-1434 | | 17. INFORMANT (Wife) ADDRESS
8 Duvall Lane Gaithersburg, MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive Hemoptysis
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) SQUAMOUS CELL CARCINOMA - Left Lung
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Ischemic Heart Disease
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
15 min.
6 mo. | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec. 19 , 19 84 , to Dec 27 , 19 84 , that (I) (we) last saw the deceased alive on Dec. 20 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Frank J. Mayo | | | | DEGREE
MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12-27-84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
FRANK MAYO | | | | 22e. ADDRESS
16220 Frederick Rd Gaithersburg, Md. 20877 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
December 31, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Silver Spring Maryland | | | |
| 24. FUNERAL DIRECTOR NAME
Robert A. Pumphrey | | | | 24b. ADDRESS
Homes, P.A. Rockville, Maryland | | 25a. DATE REC'D. BY REGISTRAR
JAN 2 1985 | | 25b. REGISTRAR'S SIGNATURE
Gelia Davidson-Randall | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 3 9 2 5
REG. NO.

| | | | | | | | |
|---|--|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Rachel M. Davidov | | | 2a. DATE OF DEATH MONTH DAY YEAR
12 12 84 | | | 2b. HOUR
1:45 AM | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
6 10 99 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.
85 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Fernwood Nursing Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Co-Business Owner | | 12b. KIND OF BUSINESS OR INDUSTRY
Drug Store | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Chevy Chase | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Louis Dwartz | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Sarah Silver | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | |
| 16b. SOCIAL SECURITY NO.
579-40-8122 | | | 17. INFORMANT ADDRESS
Bethesda, Md. 20817
Mrs. Stanley Racoosin; 6109 Plainview Rd., | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral vascular accident
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) dehydration
DUE TO, OR AS A CONSEQUENCE OF (c) dementia | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
12/10 19 84 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/12 19 84 to 12/12 19 84 , that (I) (we) lost saw the deceased alive on 12/12 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Joanne G. Crantz, MD | | | | DEGREE
MD | | 22c. DATE SIGNED
Dec. 12, 1984 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOANNE G. CRANTZ, MD | | | | 22e. ADDRESS
1229 25th St., N.W.; Washington, D.C. 20037 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/14/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Wash. Hebrew Cong. Cemetery; Washington, D.C. | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME ADDRESS
DANZANSKY-GOLDBERG MEMORIAL CHAPELS
1170 Rockville Pike; Rockville, Md. 20852 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 17 1984 | | | |
| 25b. REGISTRAR'S SIGNATURE
John E. Fisher | | | | | | | |



[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

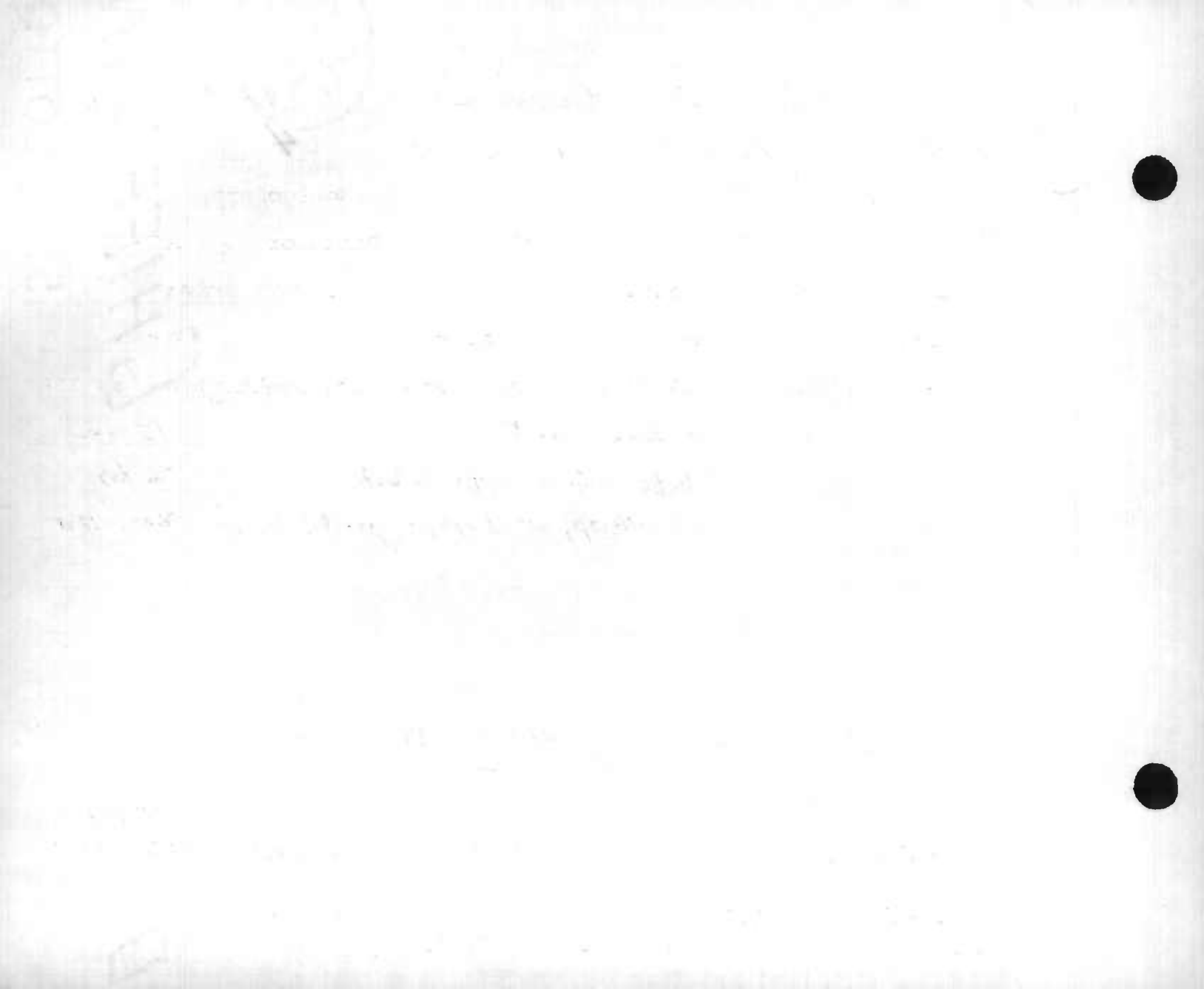
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 33926 | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Walter H. Davis Sr.</i> | | | | 2a. DATE OF DEATH
MONTH DAY YEAR <i>12-18-84</i> | | | | 2b. HOUR
<i>11:55 PM</i> | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>Black</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR <i>11-26-20</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>64</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>New York</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Maryland</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Holy Cross Hospital</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Director</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>AFLCIO</i> | |
| 13a. STATE
<i>Md.</i> | | 13b. COUNTY
<i>Mont.</i> | | 13c. CITY OR TOWN
<i>S.S.</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<i>1103 Nora Drive 20904</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Harold Davis</i> | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Daisy Cooper</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>Yes</i> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<i>WWII</i> | | 17. INFORMANT
<i>Allison Davis (Daughter)</i> | | ADDRESS
<i>Same as 13E</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>cardiac arrest</i> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>15 min</i> | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | (b) <i>lactic acidosis, septic shock</i>
<i>36 hrs</i> | |
| (c) <i>chemotherapy induced aplasia; prostate cancer</i>
<i>36 hrs; 10 yrs</i> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY, OFFICE FARM ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/17</i> , 19 <i>84</i> , to <i>12/18</i> , 19 <i>84</i> , that (I) (we) lost
saw the deceased alive on <i>12/18</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Bruce A. Silver</i> | | | | DEGREE
<i>MD</i>
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
<i>12/19/84</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>BRUCE A. SILVER</i> | | | | 22e. ADDRESS
<i>106 Irving St., N.W. Wash. D.C. #421 20010</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>12/22/84</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Geo. Wash. Mem. Park</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Paramus Bergen N.J.</i> | | | |
| 24. FUNERAL DIRECTOR
<i>Hines/Rinaldi 11800 New Hamp. Ave. S.S. Md.</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>DEC 21 1984</i> | | | | | |
| 25b. REGISTRAR'S SIGNATURE
<i>Patricia Davidson-Randall</i> | | | | | | | | | |

BP



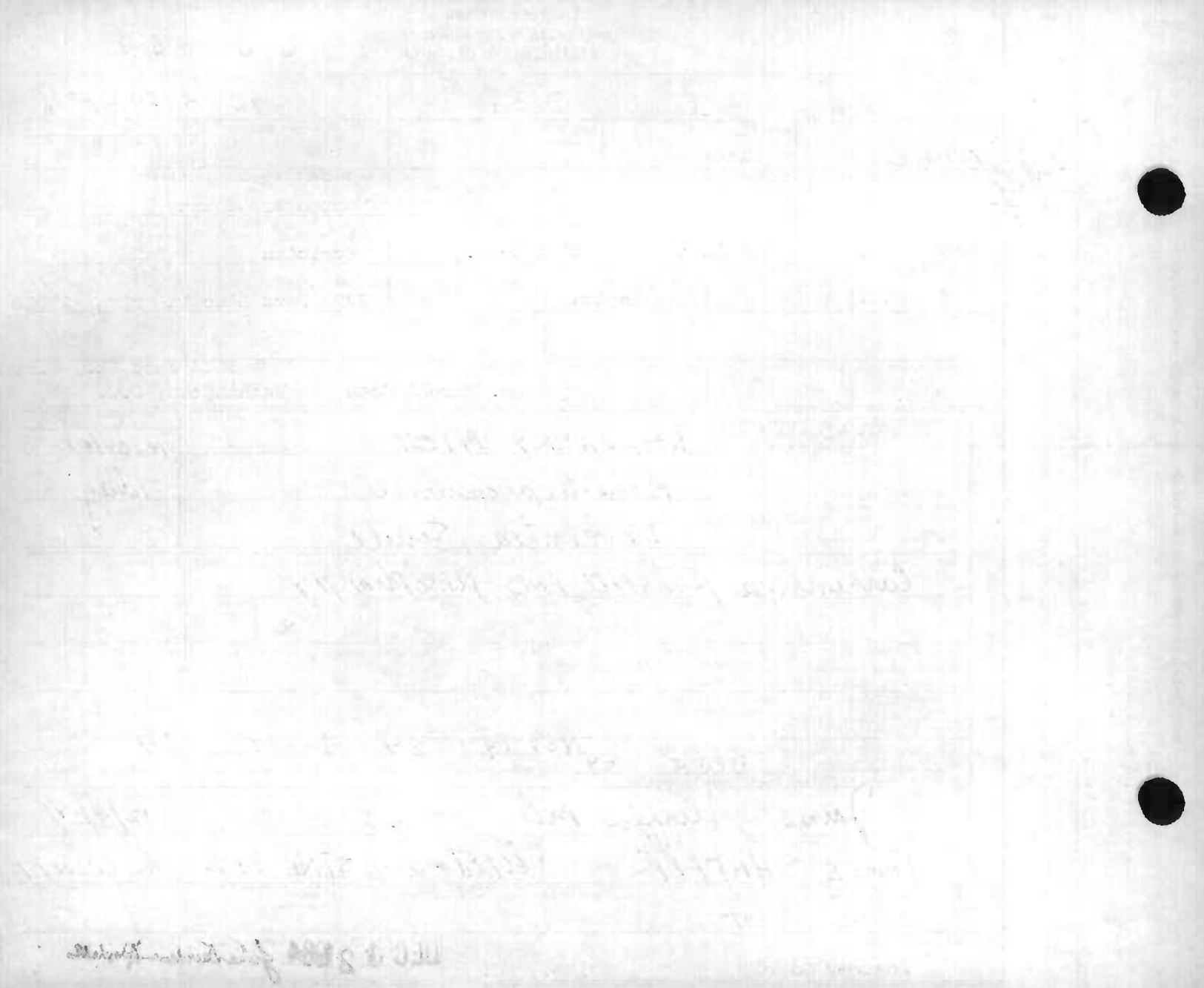
TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cover-papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH 843 3 9 2 1
REG. NO.

| | | | | | | | | | |
|---|--|--|---|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<u>Junior U Dean</u> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<u>12 5 84</u> | | | 2b. HOUR
<u>9²⁵ AM</u> | | | |
| 3. SEX
<u>male</u> | | 4. RACE
<u>Black</u> | | 5. DATE OF BIRTH
MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
<u>99</u> | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 8. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | | 9b. CITIZEN OF WHAT COUNTRY? | | 9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Montgomery County</u> MD. | | | |
| 10. CITY OR TOWN OF DEATH
<u>Tacoma Park</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Washington Adventist Hosp.</u> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Musician</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>Band</u> | |
| 13a. STATE
<u>M D.C.</u> | | 13b. COUNTY
<u>Washington</u> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<u>3298 Fort Lincoln Drive 20018</u> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<u>Unkn.</u> | | 16b. SOCIAL SECURITY NO.
<u>091-09-9155</u> | | 17. INFORMANT
<u>Mr. Harold Dean</u> | | ADDRESS <u>5124 Just St., N.E.</u>
<u>Washington, D.C.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchopneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Dementia, Seizure</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>minutes</u>
<u>1 day</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a
<u>Carcinoma Prostate AND NASOPHARYNX</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 19</u> , 19 <u>84</u> , to <u>Dec 5</u> , 19 <u>84</u> , that (I) (we) lost
saw the deceased alive on <u>Dec 5</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>James Shaffer MD</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>12/5/84</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>JAMES SHAFFER</u> | | | | 22e. ADDRESS
<u>601 Edgewood ST NE Washington DC 20017</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>Removal</u> | | 23b. DATE
<u>12/7/84</u> | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR
NAME
<u>Anatomy Board</u> | | | | ADDRESS
<u>Balto., Md.</u> | | 25. DATE REC'D. BY REGISTRAR
<u>DEC 12 1984</u> | | | |
| | | | | | | REGISTRAR'S SIGNATURE
<u>John Davidson-Hendall</u> | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH33928
REG. NO.

| | | | | | |
|--|---|---|---|--|-----------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Margaret L Deffer</i> | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>12-10-84</i> | | 2b. HOUR
<i>3:28 P.M.</i> | |
| 3. SEX
<i>Female</i> | 4. RACE
<i>Caucasian</i> | 5. DATE OF BIRTH MONTH DAY YEAR
<i>7-25-99</i> | | 6. AGE IN YEARS (LAST BIRTHDAY)
<i>85</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Wash. D.C.</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Silver Spring</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT U.S. CHFC, CLINIC, OR STREET ADDRESS)
<i>Holy Cross Hospital</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Homemaker</i> | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. NAME 13b. CITY OR TOWN
<i>Margaret PG Adolph</i> | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS ZIP CODE
<i>10103 Ashfield Rd</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<i>Charles W Brooke</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<i>Margaret Thomas</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, INCLUDE UNKNOWN)
<i>None</i> | |
| 16b. SOCIAL SECURITY NO.
<i>217 32 3123</i> | | 17. INFORMANT
<i>Same as above</i>
<i>Doris DiSilvestre (Daughter)</i> | | | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>cardiac arrhythmia</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF
(b) <i>arteriosclerotic heart disease</i> | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) <i>organic brain syndrome</i> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). | | |

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/>
AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (we) (this hospital) attended the deceased from <i>Dec 10, 1984</i> to <i>Dec 10, 1984</i> that (I) (we) last saw the deceased alive on <i>Dec 10, 1984</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Dr. Joseph Solinas for Dr. Roger</i> | | | | DEGREE
<i>MD</i> | | 22c. DATE SIGNED
<i>12/10/84</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Dr. Joseph Solinas MD</i> | | | | 22e. ADDRESS
<i>9801 Georgia Ave, S.S.Md.</i> | | | |

| | | | |
|---|------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | 23b. DATE
<i>12/13/84</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>Arlington Cemetery</i> | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Arlington, Va.</i> |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>Hines/Rinaldi 11800 New Hamp.Ave.S.S.Md.</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>DEC 12 1984</i> | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davis</i> |

4200

Proton 1000 1000 1000

1000 1000 1000 1000

1000 1000 1000 1000

1000 1000 1000

1000 1000

1000 1000

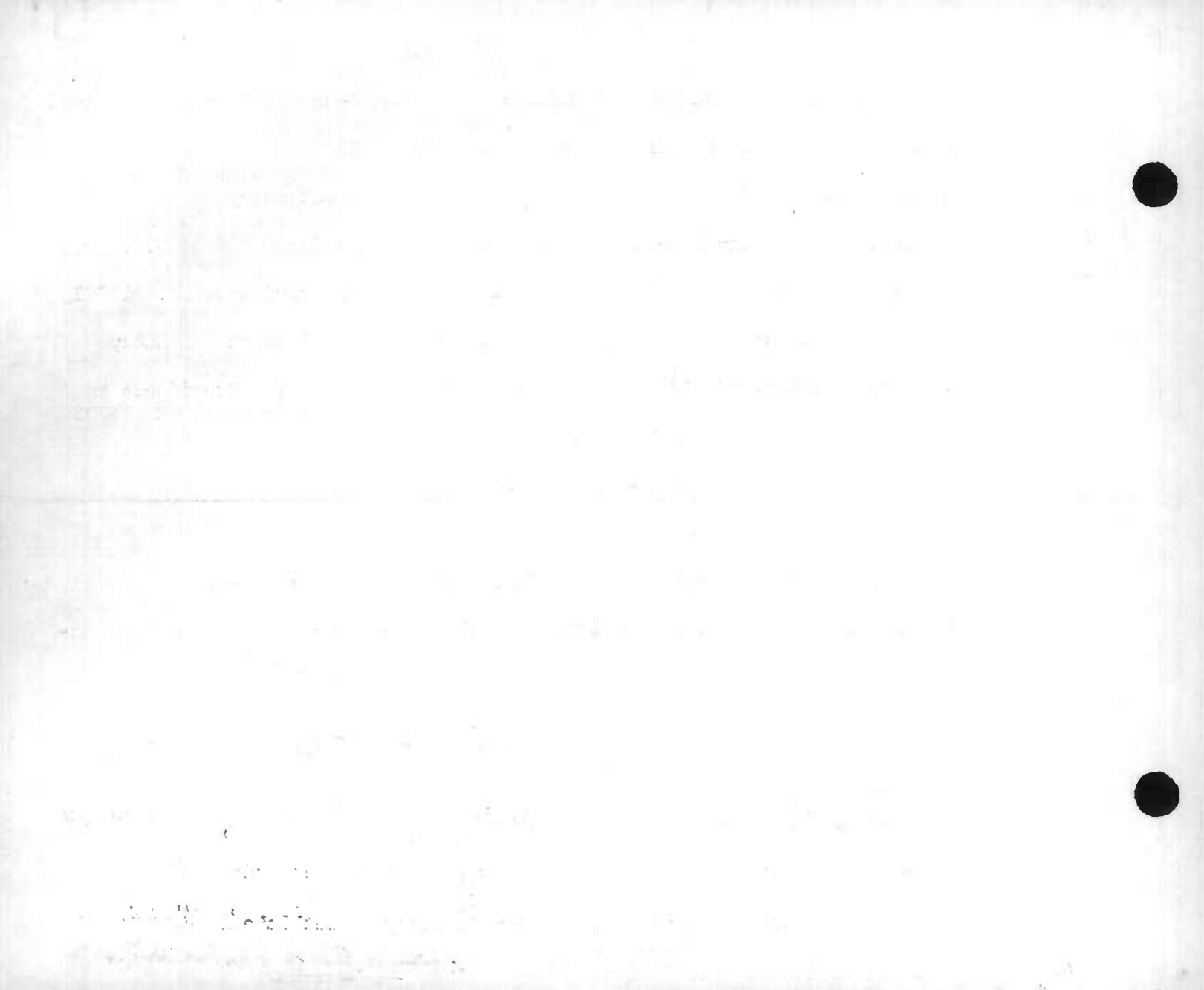
Green 1000 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified of and

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 3 3 9 2 9
REG. NO. | | | |
|---|--|--|--|---|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
John Joseph Degnan | | | | | | 2a. DATE OF DEATH
December 7 1984 | | | | 2b. HOUR
1436 M | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
Nov 20 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 | | 7. UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | 8. UNDER 24 HRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Naval Hospital Bethesda, MD | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Army | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE
Delaware | | 13b. COUNTY
New Castle | | 13c. CITY OR TOWN
Clairemont | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
703 Providence Rd. 19703 | | | | | |
| 14. FATHER'S NAME
William Ignatious Degnan | | | | 15. MOTHER'S MAIDEN NAME
Katherine Elizabeth Lucey | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
yes <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNK <input type="checkbox"/>
Army (IF YES, GIVE YEAR) | | | | 16b. SOCIAL SECURITY NO.
1947-1967 171-09-2822 | | 17. INFORMANT
Mary Degnan Green | | ADDRESS
703 Providence Rd
Clairemont, DE 19703 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive Hemorrhage
DUE TO, OR AS A CONSEQUENCE OF (b) Ruptured Abdominal Aortic Aneurysm
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
DUE TO, OR AS A CONSEQUENCE OF (c) None | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a
Lung Cancer, Pneumonia, Chronic Obstructive Pulmonary Disease | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
7 December 1984 | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Ruptured Abdominal Aortic Aneurysm | | | | 20a. AUTOPSY?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MED. EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 24 October 19 84 to 7 Dec 19 84
saw the deceased alive on 7 Dec 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Richard L Nemeo MD | | | | DEGREE
MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
8 DEC 84 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Richard L Nemeo | | | | 22e. ADDRESS
Naval Hospital Bethesda, MD | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
Dec. 12, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Savior Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Bethlehem, PA | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Ives Funeral Home | | | | ADDRESS
Arlington, VA
2847 Wilson Blvd | | 24. DATE RECEIVED BY REGISTRAR
DEC 12 1984 John Davidson-Randall | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as soon as possible.

RELEASED BY DR. TADDER

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|---|---|--|---|--|---|----------------------------|
| 1. FOR STATE REGISTRAR | | | | | 33930
REG. NO. | | | | |
| 1 DECEASED NAME (TYPE OR PRINT)
FIRST Robert MIDDLE W. LAST DePuy
Robert W DePuy | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12-8-84 | | | 2b. HOUR
2:16 AM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
Oct. 10 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ohio | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery Co. MD. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Supervisor | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Gov't. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Rockville | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
6431 Windermere Circle 20852 | | |
| 14. FATHER'S NAME FIRST I. MIDDLE N. LAST DePuy | | | | | 15. MOTHER'S MAIDEN NAME FIRST Lulella MIDDLE Phaler LAST Phaler | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | | | 16b. SOCIAL SECURITY NO. WW11 | | 17. INFORMANT ADDRESS Wexford, Pa.
Robert W DePuy, Jr. 2640 Lansdale Dr. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiovascular Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Emphysema
DUE TO, OR AS A CONSEQUENCE OF (c) Seizures | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 hours | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec. 8, 1984, to Dec. 8, 1984, that (I) (we) lost the deceased alive on Dec. 8, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Jay Ocun, MD | | | | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/8/1984 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jay Alan Ocun, M.D. | | | | | 22e. ADDRESS 20016 3301 New Mexico Ave., N.W. Wash., D.C. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 12/11/1984 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Maryland | | |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Wash., D.C./ | | | | | 25a. DATE REC'D. BY REGISTRAR 12/11/84 25b. REGISTRAR'S SIGNATURE | | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

33931

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|--|---|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) EVA C. Devine | | | 2a. DATE OF DEATH MONTH 12 DAY 4 YEAR 84 | | | 2b. HOUR 10:30 M | | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH Sept. DAY 21 YEAR 1891 | | 6. AGE (IN YEARS LAST BIRTHDAY) 93 | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | IF UNDER 24 HRS
HOURS 0 MIN. 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Kensington | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF DECEASED IN A HOSPITAL, NURSING HOME, OR OTHER INSTITUTION, GIVE NAME AND ADDRESS) Kensington Gardens Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK) retired Clerk | | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't. | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Germantown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 13035 Shadyside Lane 20874 | | | |
| 14. FATHER'S NAME William C. Clements | | | | 15. MOTHER'S MAIDEN NAME Mary Willett | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 578-01-0097 | | 17. INFORMANT ADDRESS Patricia A. Drumm same as 13e | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Pneumonia**

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
24-36 hours

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **arteriosclerotic cardiovascular disease**

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. **19**

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from **2/4 19 84** to **12/4 19 84** that (I) (we) last
saw the deceased alive on **12/4 19 84** and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

B.N. ROSENBAUM, M.D.**3720 FARRAGOT AVE.
KENSINGTON, MD. 20995**

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) **Burial**

23b. DATE **12/6/84**23c. NAME OF CEMETERY OR CREMATORY **Gate of Heaven Cemetery**

23d. LOCATION
CITY OR TOWN **Silver Spring, Maryland**

24. FUNERAL HOME OR OTHER ORGANIZATION
**Tyson Wheeler Funeral Home, Inc.
1331 Rockville Pike, Rockville, Md. 20852**

25a. DATE REC'D. BY REGISTRAR

DEC 7 1984

25b. REGISTRAR'S SIGNATURE

William H. Haddell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

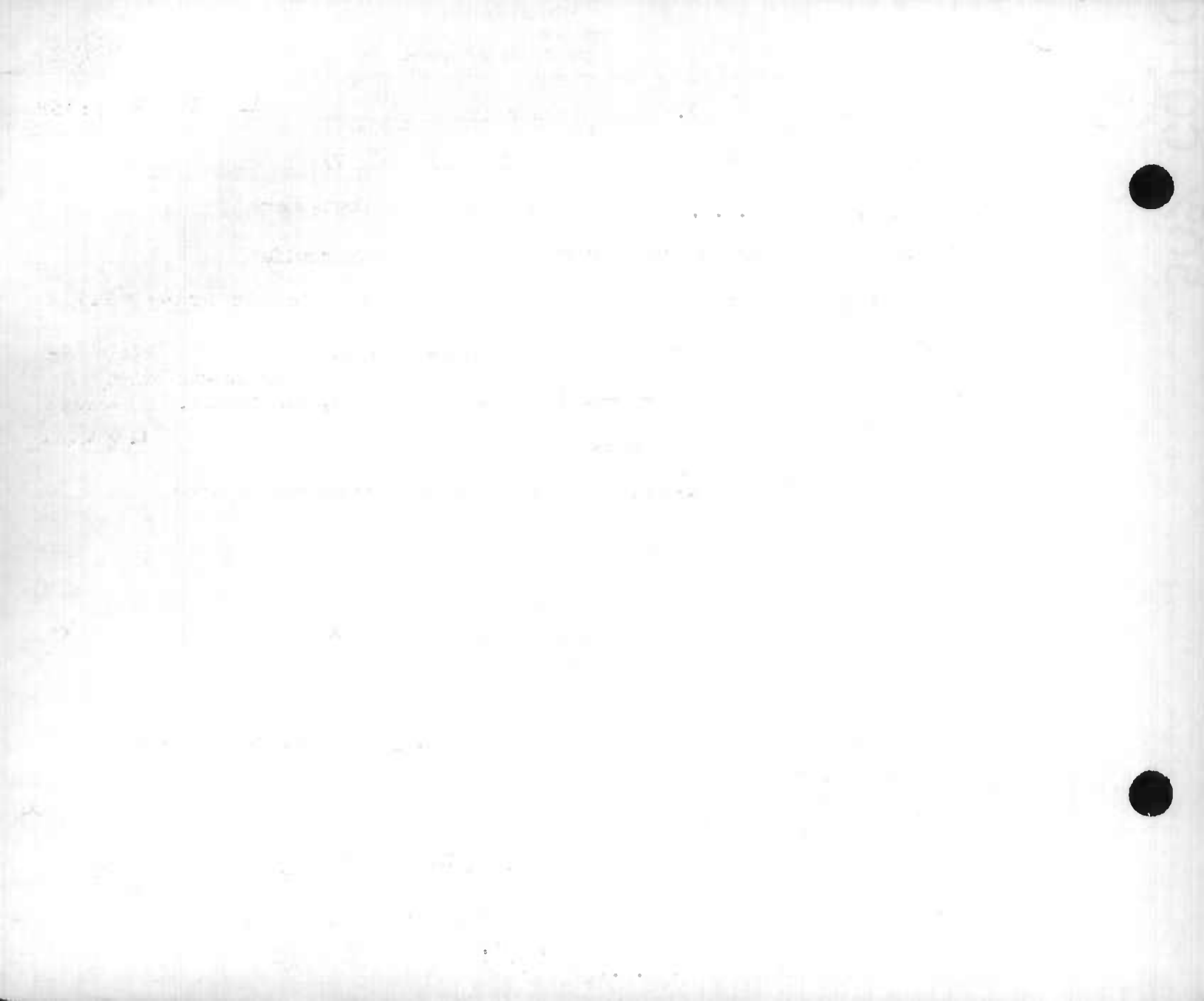
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|---|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | 3 3 9 3 2
REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
Mary I. Dewhirst | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 14 84 | | | 2b. HOUR
8:05 PM | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 29 06 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, DC | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Wheaton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Manor Care Wheaton | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Frederick | | 13c. CITY OR TOWN
Ijamsville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2995 Summit Drive 21754 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Adelmo Sorivi | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Francesca Casinadre | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | 16b. SOCIAL SECURITY NO.
212-12-4100 | | 17. INFORMANT
ADDRESS
2995 Summit Drive
Christine Mathews, Ijamsville, MD 21754 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) C.V.A.
DUE TO, OR AS A CONSEQUENCE OF
(b) atherosclerotic cardio-vascular disease
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
48 hours | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NO: WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 19 82, to 12/14 19 84, that (2) (we) lost saw the deceased alive on 12/14 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Edward P. Taubman | | | | | DEGREE
MD. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
12/15/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Edward P. Taubman | | | | | 22e. ADDRESS
1811 Prince Philip Dr., Olney MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
12/18/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland, MD | | |
| 24. FUNERAL DIRECTOR
NAME
Hines/Rinaldi Funeral Home, Inc.
11800 New Hampshire Avenue, S.S., MD 20904 | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 17 1984 | | | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|---|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) John I Dickerson | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-11-84 | | | | | 2b. HOUR
3:10 PM | |
| 3 SEX
male | | 4 RACE
Black | | 5 DATE OF BIRTH
MONTH DAY YEAR
10 14 06 | | 6 AGE (IN YEARS LAST BIRTHDAY)
78 | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Kentucky | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | | | | |
| 10 CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Air Craft Mechanic | | | 12b. KIND OF BUSINESS OR INDUSTRY
Retired | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
S.S. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
11700 Old Columbia Pike | | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
UNK Dickerson | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Clare Carrie Dickerson | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
None | | | | | 16b. SOCIAL SECURITY NO.
331 10 3556 | | 17 INFORMANT
ADDRESS
Carolyn Dickerson (Wife) Same as 13E | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Cardiogenic Shock
DUE TO, OR AS A CONSEQUENCE OF
(c) Myocardial Infarction | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 days
6 days
5 weeks | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
1) Adenocarcinoma Right Pleural Cavity 2) Pleural Effusion Right 3) Azotemia | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from January 19 83 to December 11 19 84 , that (I) (we) last saw the deceased alive on Dec. 11 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Alan R. Gair MD | | | | DEGREE | | | | 22c. DATE SIGNED
12/11/84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ALAN R. Gair MD | | | | 22e. ADDRESS
11700 Old Columbia Pike Silver Spring, Md 20904 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | | 23b. DATE
12/12/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Lee's Crematory | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Wash.D.C. | | |
| 24 FUNERAL DIRECTOR
NAME
Hines/Rinaldi 11800 New Hamp.Ave.S.S.Md | | | | | | 25a. DATE REC'D BY REGISTRAR
DEC 12 1984 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | |

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THE UNIVERSITY OF CHICAGO
LIBRARY

BLISS



My dear Mr. Bliss,
I have just received your letter of the 11th inst. and am
glad to hear that you are interested in the
study of the history of the University of Chicago.
I am sure that you will find the material
very interesting and valuable.

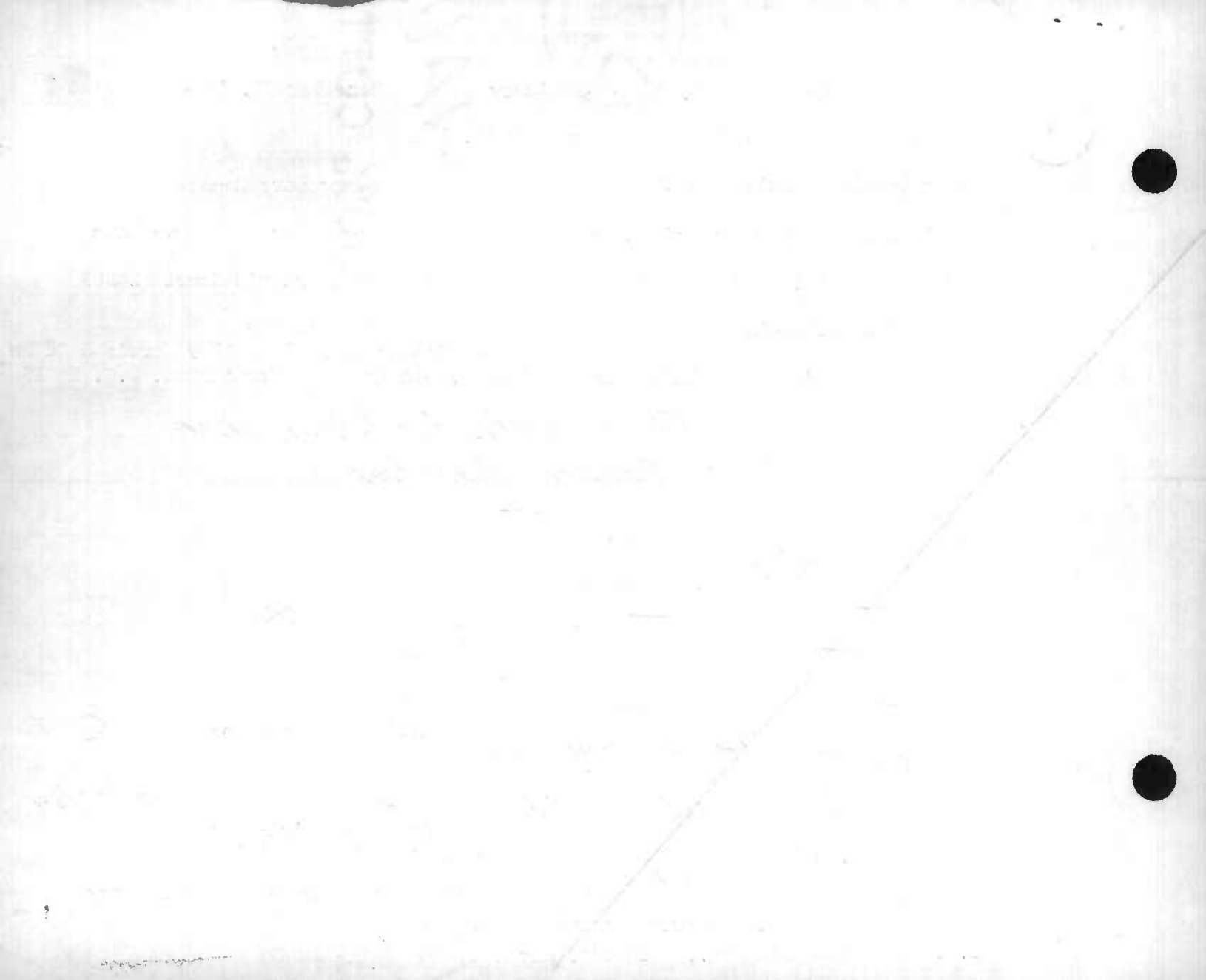
Very truly yours,
[Signature]
[Name]
[Address]
[City, State, Zip]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|---|---------------------|--|--|
| 1. FOR STATE REGISTRAR | | | REG. NO. 33934 | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
Mayfred G. Dickey | | | 2a. DATE OF DEATH
December 22, 1984 | | | | 2b. HOUR
9:00 am | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
October 13, 1922 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Kensington | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3508 Astoria Court | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Kensington | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3508 Astoria Court 20895 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Not Available | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Not Available | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | | 17. INFORMANT (Sister in Law)
Hilda F. Dickey | | 17b. ADDRESS
3709 Harrison St NW
Washington, D.C. 20015 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Chronic obstructive Pulmonary Disease</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Tobacco Addiction</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u> | | | | | | | | | |
| 19a. DATE OF OPERATION
— | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
— | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
— | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
— | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 <u>63</u> to <u>present</u> 19 <u>84</u> , that (I) (we) lost <u>Dr. G</u> <u>84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>John B. Umhau</u>
22b. PHYSICIAN'S NAME (TYPE OR PRINT)
John B. Umhau | | | | 22c. DEGREE
MD
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22d. DATE SIGNED
12/22/84 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
December 26, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Memorial Park | | 23d. LOCATION
Baltimore City and County Montgomery MD | | | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey
P.A. 7557 Wisconsin Ave., Bethesda, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 24 1984 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

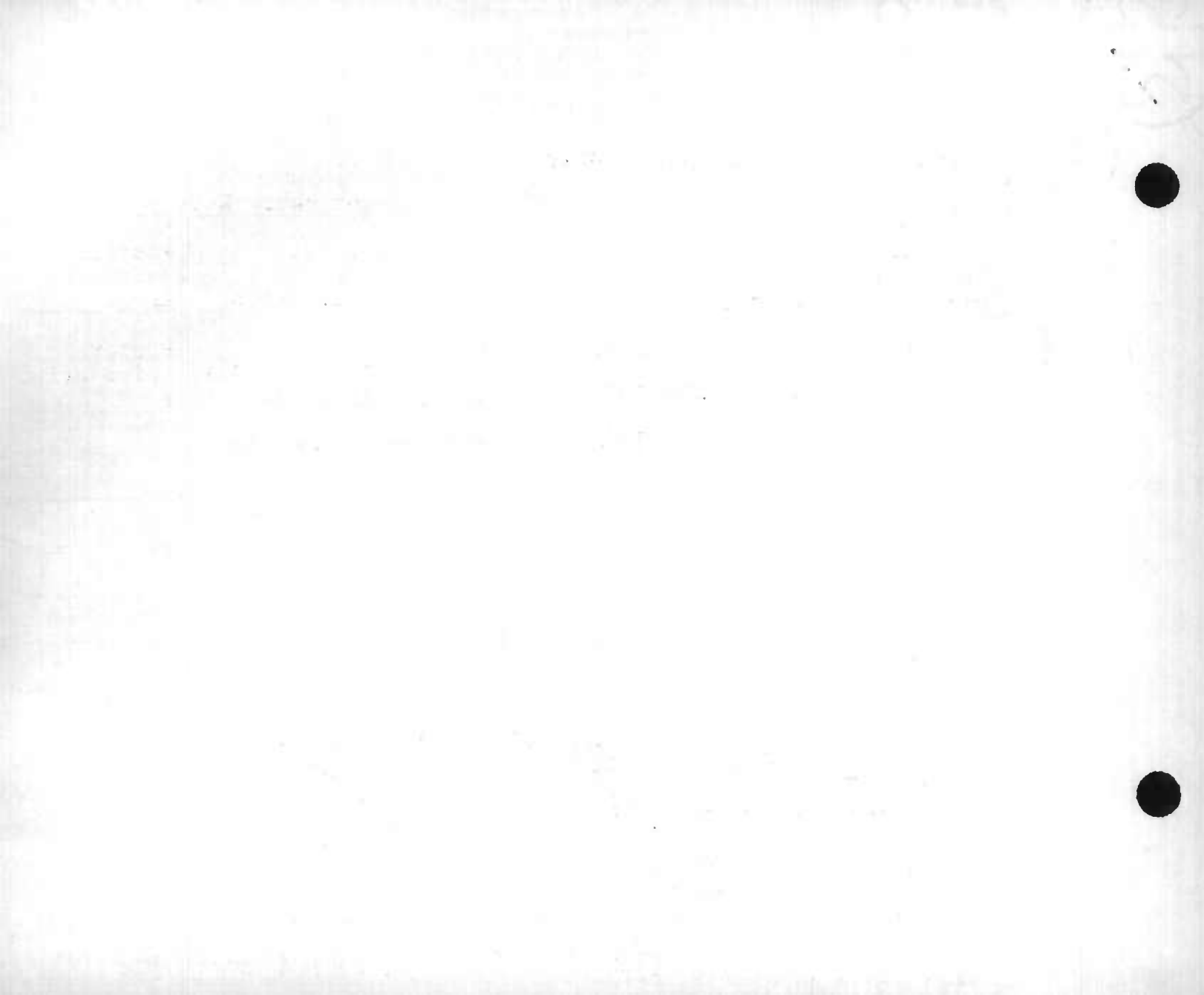
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. FOR
STATE
REGISTRAR | | 3 3 9 3 5 | | REG. NO. | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
Gordon Porter Dillon | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/16/84 | | 2b. HOUR
1127 A | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 15, 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | | 7. UNDER 1 YEAR
MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Colorado | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Chemist | | 12b. KIND OF BUSINESS OR INDUSTRY
Plastics | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
9817 Veirs Drive #2 20850 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Morris N. Dillon | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bertha Porter | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | | 17. INFORMANT (Wife)
Nettie M. Dillon, Rockville, MD | | ADDRESS
9817 Veirs Drive | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ASHD, ADRYTHMIA</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from August 19, 84 to 15 Dec 1984, that (I) (we) saw the deceased alive on above, (I) (we) (did not) see the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Thomas E. Rooley, MD | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
Dec. 16, 1984 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
THOMAS E. ROOLEY, MD | | 22e. ADDRESS
17904 GEORGETOWN AVENUE
OLNEY, MARYLAND 20822 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
December 19, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Memorial | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 18 1984 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 33936 | |
|--|--|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ALAN M. DISNEY | | | | | | 20. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> Dec 16 1984 | | 21. HOUR 9:20 P M | | 22. DATE
PRONOUNCED DEAD Dec 16 1984 | |
| 2. SEX F | | 3. RACE W | | 4. DATE OF BIRTH
MONTH DAY YEAR Feb. 28 1897 | | 5. AGE (IN YEARS)
(LAST BIRTHDAY) 87 YRS. | | 6. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | | 7. IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mont. General Hosp | | | | 12a. USUAL OCCUPATION (TYPE WORK FOR MOST OF WORKING LIFE)
POSTMASTER | | 12b. KIND OF BUSINESS OR INDUSTRY
GOVT. | | | |
| 13a. USUAL RESIDENCE (IF IN HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE MD COUNTY Howard CITY OR TOWN Highland | | | | | | 13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13c. STREET ADDRESS
BOX 13405 HIGHLAND MD 20777 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOSHUA D. DISNEY | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
AMELIA JOHNSON | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) NO | | | |
| 16b. SOCIAL SECURITY NO.
216/32/3451 | | | | 17. INFORMANT
LILLIAN DISNEY | | | | ADDRESS BOX 13405 HIGHLAND MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Dis.
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. Chronic Myocardial Dis Yrs
(b) Chronic Myocardial Dis
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Fract. T. hip | | | | | | | | | | | |
| 19a. DATE OF OPERATION
12-12-84 | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
Fract. T. hip | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR on 12-10-84 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Fell at home | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
Home | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Highland Howard Md | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE John S. Rogers | | | | | | TITLE (SPECIFY)
M.D. Dep | | MEDICAL EXAMINER | | DATE SIGNED Dec 17 1984 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | | | ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | | 23b. DATE
12/19/84 | | 23c. NAME OF CEMETERY OR CREMATORY
MT. ZION CHURCH CEM. | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
HIGHLAND HOWARD MD | |
| 24. FUNERAL DIRECTOR
NAME
SLACK FUNERAL HOME | | | | | | ADDRESS
BOX 268 ELLICOTT CITY, MD 21043 | | 25a. DATE REC'D. BY REGISTRAR
DEC 21 1984 | | 25b. REGISTRAR'S SIGNATURE
Davidson-Randall | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

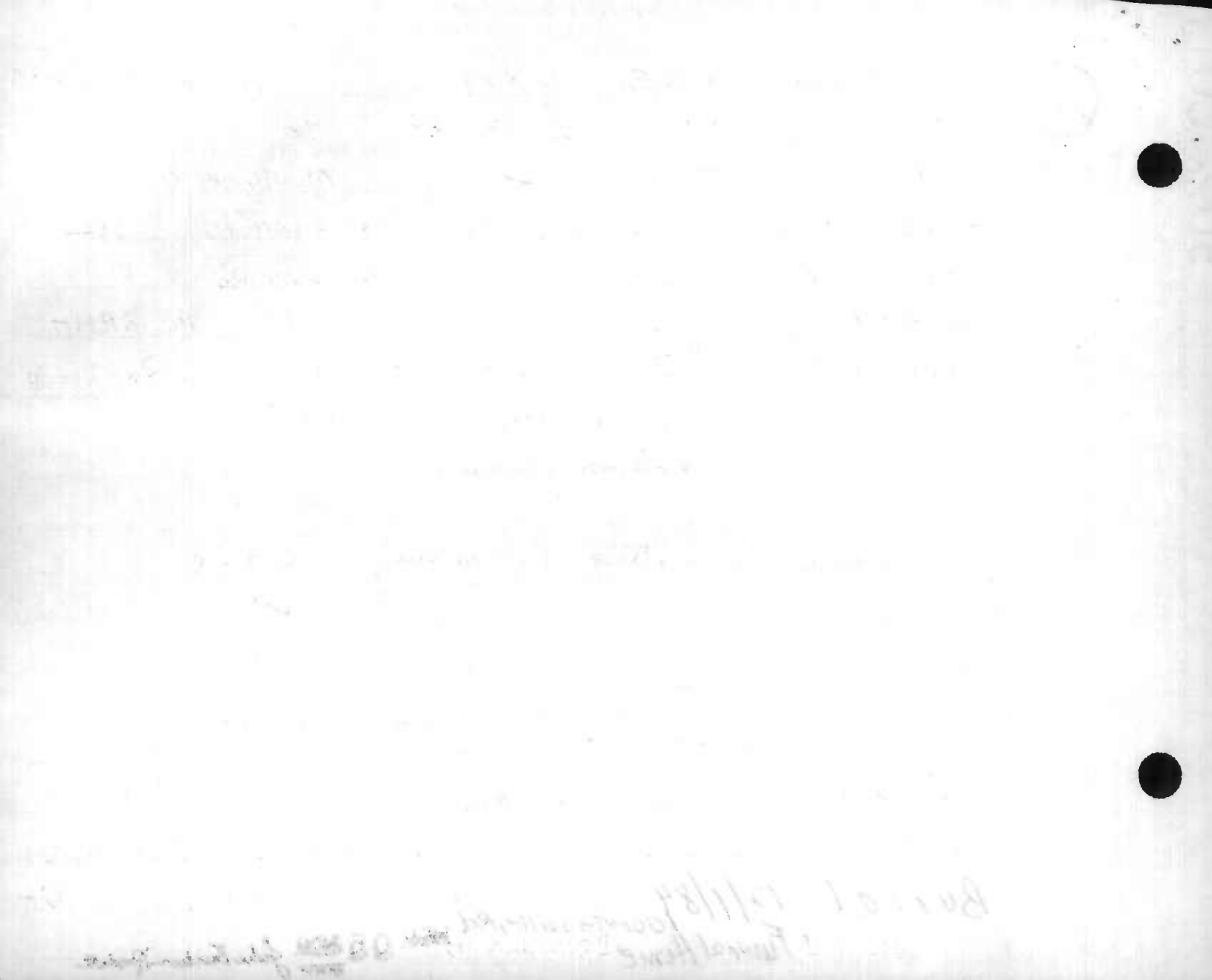
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72-hour after death report with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1. DECEASED NAME | | 2a. DATE OF DEATH | | 2b. HOUR | |
|--|--|--|---|--------------------------------|--------------------------------------|
| FIRST | MIDDLE | MONTH | DAY | YEAR | |
| MARGARET ELLAEN DIXON | | 11 | 28 | 84 | 7:50pm |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. BALTIMORE CITY OR COUNTY OF DEATH |
| F | W | 2 8 88 | 96 | | MONTGOMERY |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| Mo | USA | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Rockville | 802 Bowie Rd Rockville, Md | NEVER EMPLOYED | N/A | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | |
| Mo | MONTG | Rockville | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 802 Bowie Rd 20862 | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | | | | |
| STEPHEN | SNOOTS | | M O BAHIA | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS | | |
| NO | WA-361368 | JANE E. FAHEY | 802 Bowie Rd Rockville, Md | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>atherosclerosis</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic obstructive Pulmonary Disease</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| | HOUR A.M. MONTH DAY YEAR | | | | |
| | P.M. 19 | | | | |
| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION | | | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 <u>63</u> to 11-28, 19 <u>84</u> , that (I) (we) last saw the deceased alive on 11-28, 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | DEGREE | | 22c. DATE SIGNED | | |
| Donald R. Bucy / SN Jones MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 11-29-84 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS | | | | |
| STEPHEN N. JONES / D. Bucy | Viera Mill Rd Rockville, Md | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (WHICH?) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION | | |
| Burial | 12/1/84 | LOVETSVILLE UNION | LOVETSVILLE COUNTY STATE | | |
| 24. FUNERAL DIRECTOR | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| NAME | ADDRESS | | | | |
| Williams Funeral Home | 100 Petersville Rd BRONSWICK VA | | 05 Nov 84 | | |

BP



But not 10/1/84
10/1/84
10/1/84

07/84
25M

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. EXECUTE PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP_____

DHMH - 17

(VR A15 ME (5))

| | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|----------|--|
| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 33938 | |
| 1- STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT)
Paul Anthony Doane | | | | | | 2a. DATE KNOWN OF DEATH
12-10-84 | | 2b. HOUR
3:40P | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
Nov. 6, 1964 | | 6. AGE (IN YEARS)
20 YRS. | | 7. DATE PRONOUNCED DEAD
12-10-84 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash. D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED
WIDOWED | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County | | 10. CITY OR TOWN OF DEATH
Silver Spring | | | |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Carpenter's Helper | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | | |
| 13c. CITY OR TOWN
Wheaton | | 13d. INSIDE CITY LIMITS?
YES | | 13e. STREET ADDRESS
4406 Randolph Road | | 20906 | | 14. FATHER'S NAME
Paul Doane, Jr. | | | |
| 15. MOTHER'S MAIDEN NAME
Virginia C. Rich | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
577-94-2336 | | 17. INFORMANT
Paul Doane, Jr. same as 13e | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
8152 IMMEDIATE CAUSE (a) Multiple injuries
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES | | 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
21b. TIME OF INJURY
3:30PM 12-10-84 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
driver of a moped who lost control fell off as a result wheels of a truck ran over victim | | | |
| 21d. INJURY OCCURRED WHILE AT WORK
NOT WHILE AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
street | | 21f. LOCATION
Vine Hill Rd. | | 21g. CITY OR TOWN
Rockville, Maryland | | 22a. I certify that I took charge of the remains described above, held on death resulted from:
Natural causes
Accident
Suicide
Homicide
Undetermined manner | | | |
| 22b. TITLE (SPECIFY)
Assistant Medical Examiner | | 22c. DATE
12-11-84 | | 22d. EXAMINER'S NAME
Margarita A. Korell, M.D. | | 22e. ADDRESS
111 Penn Street | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | |
| 23b. DATE
12/14/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Forest Oak Cemetery | | 23d. LOCATION
Gaithersburg, Maryland | | 24. FUNERAL DIRECTOR
Tyson Wheeler Funeral Home, Inc.
1331 Rockville Pike, Rockville, Md. 20852 | | 25a. DATE REC'D BY REGISTRAR
DEC 19 1984 | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | 3 3 9 3 9
REG. NO. | | | | | |
|--|--|----------------------|--|--|--|--|--|--|--|---|--|--|--|-------------------------|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Hardy D. Dougherty | | | | | | | | | | | | 2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 19 12-14-84 | | | | 2b. HOUR OF ESTI 7:55 AM | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR Mar. 18 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 2 HRS. HOURS MIN. | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 19 12 14 84 | | 2d. HOUR 7:55 AM | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Defense Intelligence Agency | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE Maryland | | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 12908 Bluet Lane | | | | 20906 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Francis Dougherty | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Brown | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO. 115-07-5992 | | | | 17. INFORMANT Karen Dougherty Wife Same as 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio Respiratory Arrest
Conditions, if any, which gave rise to immediate cause (b) Severe Intra cranial Hemorrhage
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6:30 P.M. 12 8 1984 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Fell down stairs | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 12908 Bluet Lane Silver Spring Montgomery Md | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | | | | | | | | | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | |
| ACTUAL SIGNATURE John Tauber | | | | TITLE (SPECIFY) Deputy M.D. | | | | DATE SIGNED 12-14-84 | | | | 12b. REGISTRAR'S SIGNATURE Bethesda Md | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) John Tauber | | | | ADDRESS 8218 Wisconsin Ave | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Dec. 18, 1984 | | | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME Francis J. Collins | | | | ADDRESS 500 University Boulevard, W. Silver Spring, Md. | | | | 25a. DATE REC'D. BY REGISTRAR 12-14-84 | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | |

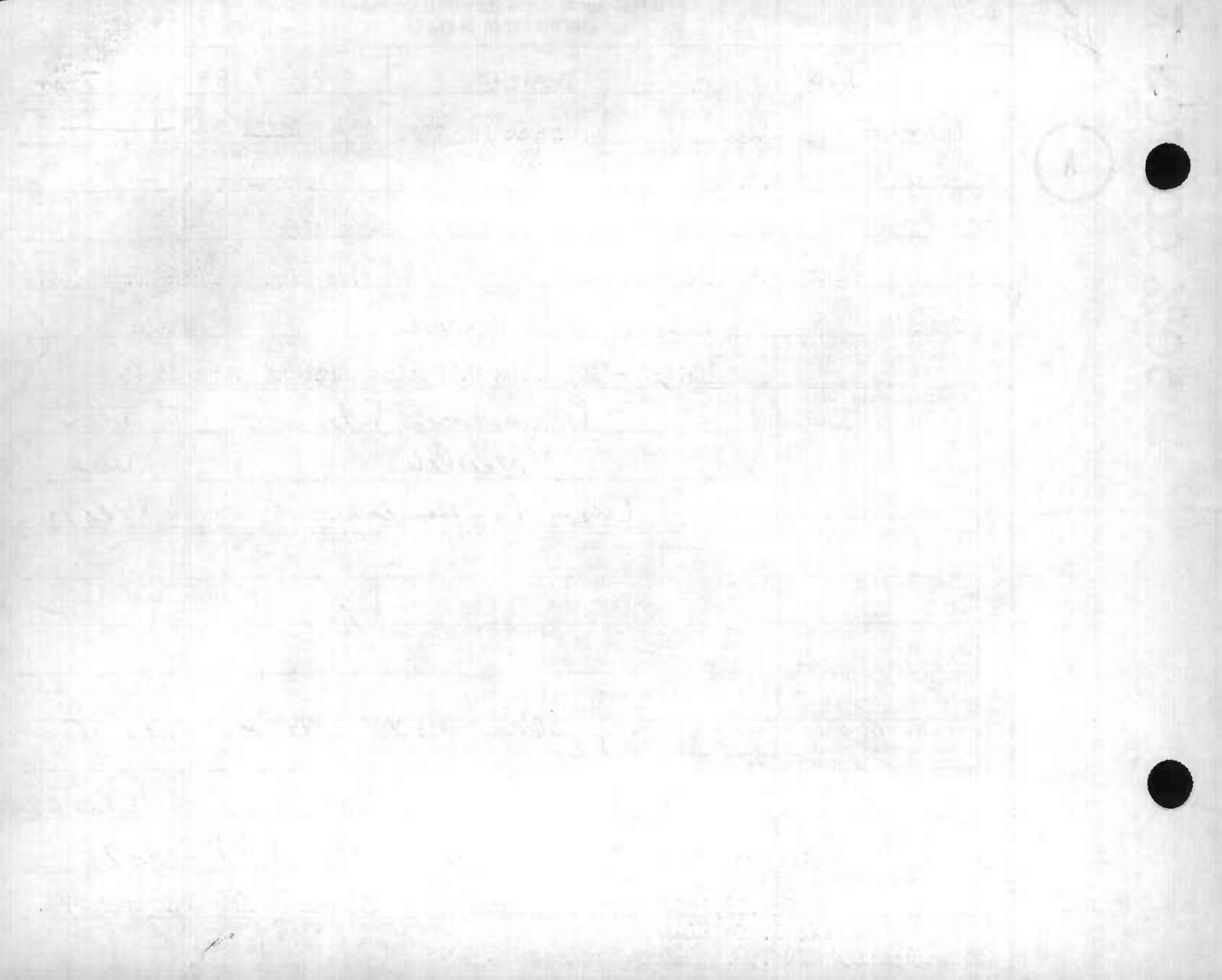
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR STATE REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1 - STATE REGISTRAR | | | | | | | | | | 3 3 9 4 0 | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | | | | | | |
| Iva C. DRAIZE | | | | | | | | | | 12/19/84 | | | | | | | | | |
| 3. SEX FEMALE | | | | | | | | | | 2b. HOUR 7 ²⁰ AM | | | | | | | | | |
| 4. RACE White | | | | | | | | | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 81 YRS. | | | | | | | | | |
| 5. DATE OF BIRTH MONTH DAY YEAR November 19, 1902 | | | | | | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD | | | | | | | | | |
| 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Takoma Park | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital | | | | | | | | | | | | | | | | | | | |
| 13a. STATE Maryland | | | | | | | | | | 13b. COUNTY Montgomery | | | | | | | | | |
| 13c. CITY OR TOWN Silver Spring | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph DeKeyser | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Euphrasia Martin | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | | | | | | | 16b. SOCIAL SECURITY NO. 578-38-4699 | | | | | | | | | |
| 17. INFORMANT John H. Draize | | | | | | | | | | ADDRESS Husband Same as 13 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumococcal Septicemia | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cellulitis | | | | | | | | | | 1 week | | | | | | | | | |
| (c) Ulcer Per For Hematomas | | | | | | | | | | 3 years | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | | | | |
| 21c. HOW INJURY OCCURRED | | | | | | | | | | 21d. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from 16 Dec 19 84 to 19 Dec 19 84, that (we) lost saw the deceased alive on 16 Dec 19 84, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22b. SIGNATURE Michael Leibowitz, MD | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Leibowitz, MD | | | | | | | | | | 22d. ADDRESS 1120 N. Hume St, 20907 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | | | | | | 23b. DATE Dec. 22, 1984 | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven | | | | | | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Francis J. Collins | | | | | | | | | | 25a. DATE RECEIVED BY REGISTRAR 12/24/84 | | | | | | | | | |
| 500 University Blvd., W. Silver Spring, Md. | | | | | | | | | | REGISTRAR'S SIGNATURE | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The physician or attending physician must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 33941
REG. NO. | | | | | |
|---|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
GOLDIE DRANETZ | | | | 2a. DATE OF DEATH MONTH DAY YEAR
DECEMBER 1, 1984 | | | | 2b. HOUR
3:40 PM | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
JUNE 16, 1890 | | 6. AGE (IN YEARS LAST BIRTHDAY)
94 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
LATVIA | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH
ROCKVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SHADY GROVE ADVENTIST HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MERCHANT | | 12b. KIND OF BUSINESS OR INDUSTRY
CLOTHING | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
MASSACHUSETTS BARNSTABLE CENTERVILLE | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
15 SACHEM DRIVE 99999 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
(UNASCERTAINABLE) (UNASCERTAINABLE) | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
(UNASCERTAINABLE) (UNASCERTAINABLE) | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
014-28-7835D | | 17. INFORMANT ADDRESS
SYLVIA ROSS 6851 TULIP HILL TERRACE, BETHESDA, MARYLAND 20816 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Aortic Stenosis
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 years
20 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
Cardiac Dysrhythmia | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 19 78 , to December 1 19 84 , that (I) (we) last saw the deceased alive on November 30 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Frederick Meyers, M.D. DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED
December 2, 1984 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
FREDERICK MEYERS, M.D. | | | | 22e. ADDRESS
916 19th STREET, N.W., WASHINGTON, D.C. 20006 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12/4/1984 | | 23c. NAME OF CEMETERY OR CREMATORY
BROCKTON PRIDES | | 23d. LOCATION
STOUGHTEN, MASSACHUSETTS | | | |
| 24. DONOR OF ORGAN TO
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME | | | | 25. DATE REC'D. BY REGISTRAR
DEC 05 1984 | | 25b. REGISTRAR'S SIGNATURE
John H. H. H. | | | |
| 23e. ADDRESS
232 CARROLL STREET, N. W., WASHINGTON, D. C. | | | | | | | | | |



DEC 18 1944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 33942
REG. NO. | |
|--|--|---|--|---|--|--|--|--|--|-------------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 7b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Hilda Bell Eacho | | | | | | 12 03 84 | | | | 11A M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
06 30 02 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash. D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Carriage Hill-Bethesda | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Executive | | 12b. KIND OF BUSINESS OR INDUSTRY
Food Wholesale | | | |
| 13a. STATE
D.C. | | 13b. COUNTY
13c. CITY OR TOWN
Washington | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2700 Calvert St. N.W. 20008 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Thomas Bell | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Grace Bendamire | | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | |
| 17. SOCIAL SECURITY NO.
577-56-8013 | | | | 17. INFORMANT
William C Eacho | | | | 17. ADDRESS
Potomac, Md. 20854
11110 Bella Vista Dr. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerosis, cerebral</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 year</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)
<u>Carcinoma of bladder & Rheumatoid arthritis</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22. I certify that (I) (the hospital) attended the deceased from <u>Nov 28 1983</u> to <u>Dec 3 1984</u> , that (I) (we) lost <u>1983</u> above, (I) (we) (did) (did not) view the body after death <u>1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | | | | | |
| 23. SIGNATURE
<u>Joseph Wallace</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 23c. DATE SIGNED
<u>12/3/84</u> | | | |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT)
Joseph Wallace, M.D. | | | | 23b. ADDRESS
5272 River Road, Bethesda, MD 20816 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/6/1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington D.C. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Joseph Gawler's Sons Inc.
5130 Wisc. Ave., N.W. Wash., D.C. | | | | | | | | | | | |

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09/25/2012

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CONFIDENTIAL - SECURITY INFORMATION

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Johns Bay, Inc.

• 70 •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

33943
REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|--|--|---|------------------------------------|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Poretha J. Eckell | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-2-84 | | | 2b. HOUR
3:47 A.M. | | | | | |
| 3. SEX
Female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 14 19 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hosp | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
own home | | | |
| 13a. STATE
Md | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1907 Liberty Dr. 20902 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Evan James | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Levinia Cease | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
-- | | 17. INFORMANT
ADDRESS
Robert R. Eckell-husband-(same as 13e) | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

1 month

3 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 7, 19 84, to 12-2, 19 84, that (1) (we) lost saw the deceased alive on 12-2, 19 84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Peter Sherer MD | | | | DEGREE
MD | | 22c. DATE SIGNED
12-2-1984 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Peter B. Sherer MD | | | | 22e. ADDRESS
3947 Ferrara Dr. Wheaton, Md | | | |

| | | | | | | | |
|--|--|------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
12-4-1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Edgehill Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
West Nanticoke Penna. | |
| 24. FUNERAL DIRECTOR
Hines/Rinaldi Funeral Home 11800 N.H. Ave., Silver Spring, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 4 1984 | | 25b. REGISTRAR'S SIGNATURE
John Harrison Rindell | |

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19-00-501

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
BESSIE EIDELSBURG | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Dec. 21, 1984 | | | 2b. HOUR
3:00pm | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 18, 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 | | 7. UNDER 1 YEAR
MONTHS DAYS
YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
15401 Bassett Lane | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
----- | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Sil. Spg. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
15401 Bassett Lane 20906 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Abraham Strauss | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Yetta (unknown) | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
unknown | | 17. INFORMANT
ADDRESS Boca Raton, Fla.
Robert E. Eidelsberg; 3089 NW 27th Terrace | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) bronchopneumonia
DUE TO, OR AS A CONSEQUENCE OF (b) lung cancer
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24 hrs
2 yrs | |
| | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NO: WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/1 19 84 to 12/21 19 84 , that (I) (we) lost
saw the deceased alive on 12/2 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Bruce A. Silver | | | | | DEGREE
MD | | | 22c. DATE SIGNED
12/21/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BRUCE A. SILVER | | | | | 22e. ADDRESS
106 Army St. N.W., Wash. DC 20010 #44 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
12-23-1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Judean Mem. Gardens | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Olney, Maryland | | |
| 24. FUNERAL DIRECTOR
NAME
Danzansky-Goldberg Chapels; 1170 Rockville Pike | | | | | 25. DATE REC'D. BY REGISTRAR
DEC 27 1984 | | | | |
| 25b. REGISTRAR'S SIGNATURE
John Davidson-Rodell | | | | | | | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

33945
REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Bertha V. Eisel | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12. 6. 84 | | 2b. HOUR
2:39 A.M. |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Nov. 29 1891 | | 6. AGE (IN YEARS LAST BIRTHDAY)
93 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Gaithersburg | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Herman Wilson Health Care Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
- |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
Md. | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Gaithersburg | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
301 Russell Ave. (20877) | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Milton T. Phelps | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Adella - Soper | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
213-10-5564D | | 17. INFORMANT (Sister) ADDRESS
Pauline J. Phelps 401 Russell Ave. #710 Gaithersburg, Md. 20877 | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Senility

DUE TO, OR AS A CONSEQUENCE OF

(b) **E.V.D.**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Gen'l. atherosclerosis**

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

Years

Years

Years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

| | | | | | |
|--|--|--|--|--|---|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 77 to 12-6 , 19 84 , that (I) have last saw the deceased alive on 12-3 , 19 84 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) view the body after death. | | | | | |
| 22b. SIGNATURE
Jack Schumacher M.D. | | | | 22c. DATE SIGNED
12-6-84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Jack Schumacher, M.D. | | | | 22e. ADDRESS
105 Russell Ave., Gaithersburg, Md. 20877 | |

| | | | |
|--|------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
12/10/84 | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Balt. Md. |
| 24. FUNERAL DIRECTOR
(NAME)
Gartner Sandison F.H. Gaithersburg, Md. 20877 | | 25a. DECEASED BY REGISTRY
DEC 11 1984 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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301 Madison Ave. (2017)

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Horizontal

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

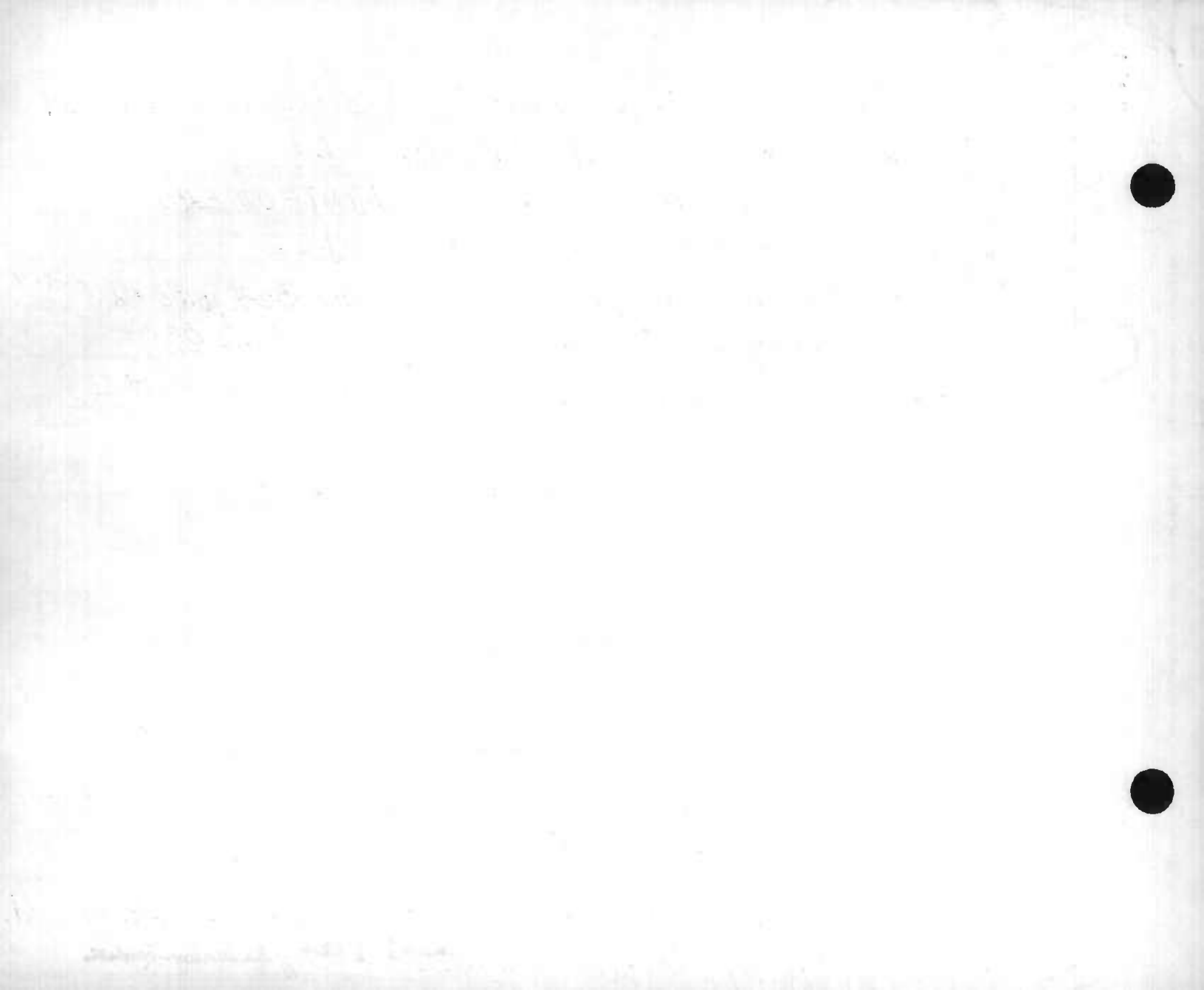
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 33946
REG. NO. | |
|--|--|---|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Eunice Terlene Ellis | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
December 5, 1984 | | | | 2b. HOUR
1657M | |
| 3. SEX
Female | | 4. RACE
Negro | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 6, 1923 | | 6. AGE (IN YEARS LAST BIRTHDAY)
61 YRS. | | 7. UNDER 1 YEAR
MONTHS DAYS
61 | | 8. UNDER 24 HRS.
HOURS MIN.
1657 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hosp. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
md. | | | | | | 13b. COUNTY
Montg. | | 13c. CITY OR TOWN
Germanstown | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST LAST
HARRY B. Clipper | | | | | | 15. MOTHER'S M maiden name
FIRST MIDDLE LAST
Ruby Washington | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
216-16-0482 | | 17. INFORMANT ADDRESS
Shirley Shields - SAME AS #13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
(b) coronary atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (his) (her) (their) attended the deceased from 4:30 19 84 , to 5 Dec 19 84 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
St H Dolnik | | | | DEGREE
MD | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/6/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Steven Dolinsky | | | | 22e. ADDRESS
15 E Dear Pk Dr G2ithersburg Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | | 23b. DATE
12-10-84 | | 23c. NAME OF CEMETERY OR CREMATORY
Seneca Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Germanstown Montg Md. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
George R. Snowden 246 N. Wash. St. Rockville, Md. 20850 | | | | | | | | | | | |
| DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
11/11/84 Julia Davidson-Randall | | | | | | | | | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | |
|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 33947 | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Janet F. Ellis | | 2a. DATE OF DEATH MONTH DAY YEAR
12/8/84 | |
| 3. SEX
Female | | 2b. HOUR
2:35pm | |
| 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
June 4, 1903 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STREET ADDRESS
8819 Main St. 20872 | | 13b. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Charles Andrew Funkhouser | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Maude Snapp | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
212-74-3317 | |
| 17. INFORMANT ADDRESS
Patricia Ellis Michos, 8804 Stonehaven Ct. Potomac, Md. 20854 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Cause undetermined, possible pulmonary embolism
DUE TO, OR AS A CONSEQUENCE OF (c)
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:
Illness, dehydration, arthritis, broken bones | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from 1:14 PM 8 Dec 19 84 to 2:35 PM 8 Dec 19 84 , that (1) (me) last saw the deceased alive on 8 Dec 19 84 , and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above, (1) (me) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Donald E. Dillon M.D. | | 22c. DATE SIGNED
8 Dec 84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
2901 Olney - Sandy Spring Rd Olney, Md 20832 | | 22e. ADDRESS
Donald E. Dillon, M.D. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Dec. 10, 1984 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Dayton | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Dayton, Rockingham, Virginia | |
| 24. FUNERAL DIRECTOR
Alan L. Molesworth, P.A., Damascus, Md. 20872 | | 25a. DATE REC'D. BY REGISTRAR
DEC 13 1984 | |
| 25b. REGISTRAR'S SIGNATURE
Gita Davidson-Rodella | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

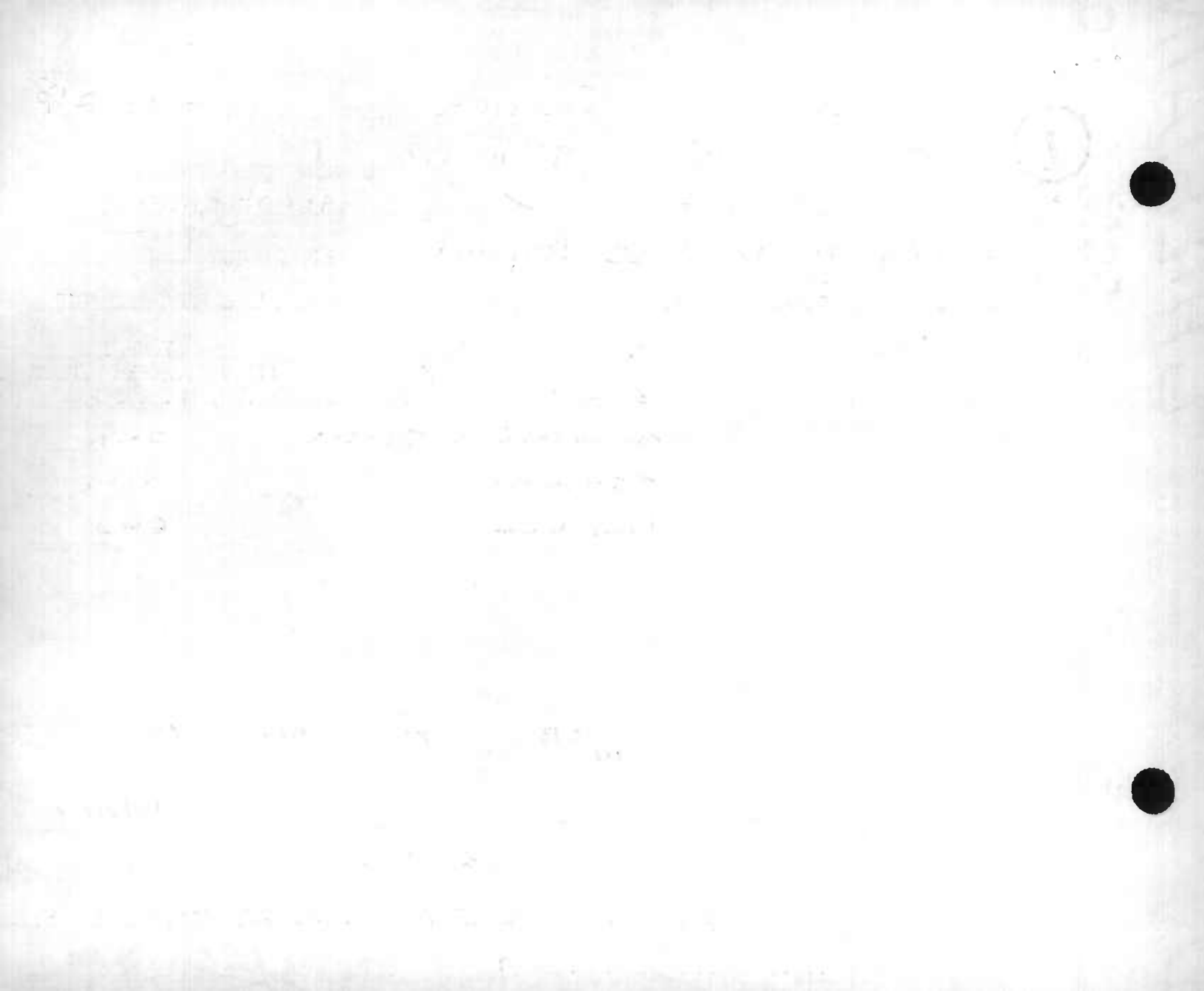
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH33948
REG. NO.

| | | | | | |
|---|---|---|---|--|---|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | MONTH DAY YEAR | | HOUR MIN. | |
| FIRST MIDDLE LAST
Ellen J Emerick | | 12 4 84 | | 2 18 M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR
MONTHS DAYS | |
| F | W | MONTH DAY YEAR
9 10 1900 | 84 | YRS. HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Tennessee | USA | | Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Silver Spring | Holy Cross Hospital | HOME MAKER | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | |
| MARYLAND | MONTGOMERY | SILVER SPRING | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 9015 ALTON PARKWAY 20910 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | 16. ADDRESS | | | |
| VIVIAN GILLIAT | TINA TOMPKINS | 17. INFORMANT
SON
11327 MITSCHER STREET
KENSINGTON, MD. 20895 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | 17. INFORMANT
MERLE SMITH | | | |
| NO | 216-46-8949 | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1: DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Gray Matter in Sepsis</u> | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>2 days</u> |
| DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Cellulitis</u> | | | | | <u>7-12</u> |
| DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Hypertension</u> | | | | | <u>6 wks</u> |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/13</u> 19 <u>84</u> to <u>12/14</u> 19 <u>84</u> , that (I) (we) lost
saw the deceased alive on <u>12/17</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
<u>Edgar A. LeVine M.D.</u>
DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>12/16/84</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
EDGAR A. LEVINE | | 22e. ADDRESS
8630 FEXTON ST. Silver Spring, Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| BURIAL | 12/11/84 | SMITHVILLE CEMETERY | N. SCITUATE PROVIDENCE R.I. | | |
| 24. FUNERAL DIRECTOR
NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| FRANCIS J. COLLINS
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | DEC 10 1984 | | Julia Davidson-Randall | |

BP _____



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

33949
REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) TILLIE ESKIN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 23 84 | | | 2b. HOUR
345 M. | | | | |
| 3 SEX
FEMALE | | 4 RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 15 97 | | 6. AGE (IN YEARS LAST BIRTHDAY)
87 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
RUSSIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
ROCKVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HEBREW HOME OF GREATER WASHINGTON | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SALES | | 12b. BUSINESS NOT INDUSTRY
RETAIL | | |
| 13a. STATE
MD | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
11200 LOCKWOOD DRIVE 20901 | |
| 14. FATHER'S NAME
MORRIS | | | MIDDLE
KURTLOFF | | 15. MOTHER'S MAIDEN NAME
(UNASCERTAINABLE) | | | MIDDLE
(UNASCERTAINABLE) | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
052-03-0288 | | 17. INFORMANT
MARVIN ESKIN, | | | ADDRESS
12612 EASTBOURNE DRIVE SILVER SPRING, MARYLAND | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) ABDOMINAL METASTASES
DUE TO, OR AS A CONSEQUENCE OF
(c) CARCINOMA OF OVARY | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 MINUTES | |
| | | | | | | | | | 2 MONTHS | |
| | | | | | | | | | 3 MONTHS | |
| | | | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: no | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from NOVEMBER 29 19 84 to DECEMBER 23 19 84 , that (1) (we) last saw the deceased alive on DECEMBER 23 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Steven Lipson | | | | | DEGREE
MD | | 22c. DATE SIGNED
12/23/84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
STEVEN LIPSON | | | | | 22e. ADDRESS
6121 MONTROSE ROAD, ROCKVILLE | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | | 23b. DATE
12/26/1984 | | 23c. NAME OF CEMETERY OR CREMATORY
MOUNT LEBANON CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ADELPHI, PR. GEO., MARYLAND | | | |
| 24. FUNERAL DIRECTOR
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 28 1984 | | | | |
| 232 CARROLL STREET, N. W., WASHINGTON, D. C. | | | | | | Registrar's Signature
John A. [Signature] | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

BP



[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "RECEIVED" and "NOV 28" are visible.]

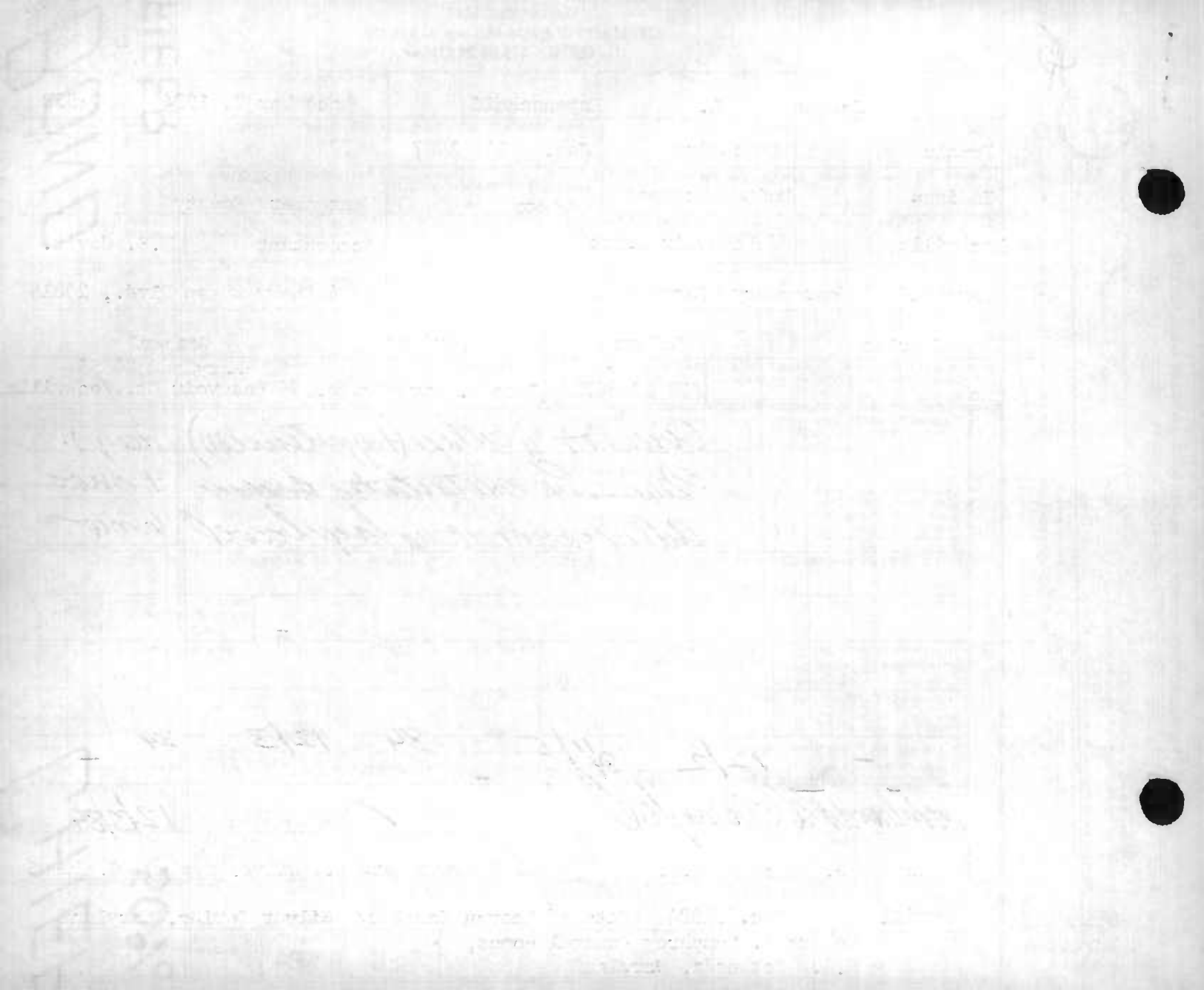


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 33950
REG. NO. | | | | |
|---|--|---|--|--|--|--|--|--------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
Jeanne L. Espenscheid | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 2, 1984 | | | | 2b. HOUR
7:55P ^M |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan. 14 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77
YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Indiana | 7b. CITIZEN OF WHAT COUNTRY?
United States | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
#6 Beauvoir Court | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Accountant | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Gov't. | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE
Maryland | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Chevy Chase | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles LeFevre | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Harriet Gossard | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES
no | | 16b. SOCIAL SECURITY NO.
579 09 6671 | | 17. INFORMANT
ADDRESS
Maryland 20855
Jane E. Bartolomeo, #6 Beauvoir Ct., Rockville. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Circulatory collapse (hypotension)</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Massive metastatic disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Adenocarcinoma large bowel</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>4 mo</u>
<u>6 mo</u> | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>no</u> | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/5</u> , 19 <u>84</u> , to <u>12/3</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>12/2</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
<u>Richard P. Delaney, M.D.</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>12/5/84</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Richard P. Delaney, M.D. | | | | 22e. ADDRESS
4323 Havard Street, Silver Spring, Md. 20906 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Dec. 5, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring, Maryland | | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey Funeral Homes,
P.A. Bethesda, Maryland | | 25a. DATE REC'D. BY REGISTRAR
DEC 6 1984 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | | |

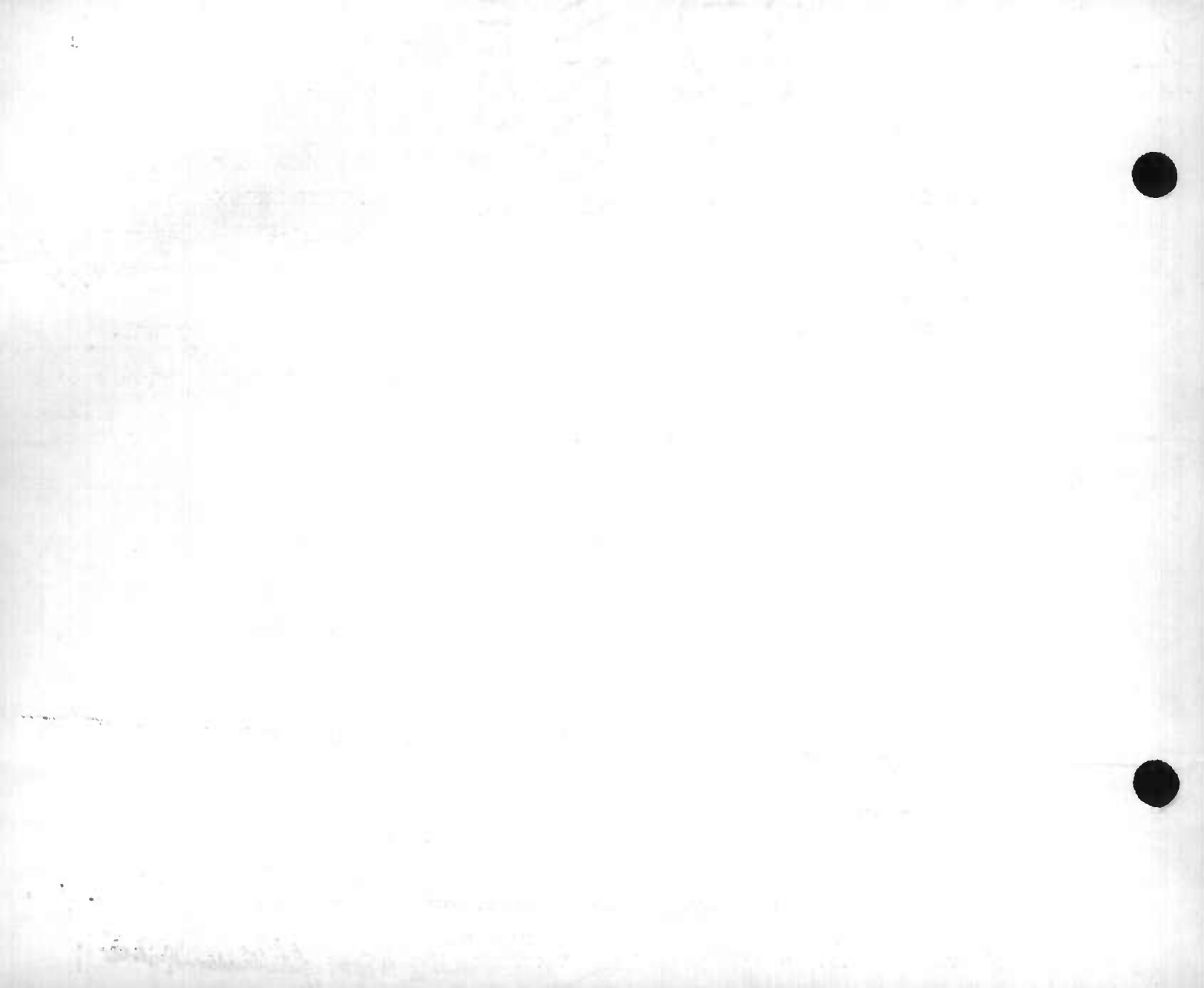


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|--|--|---|--|----------------------|--|
| 1- FOR STATE REGISTRAR | | 3 3 9 5 1 | | REG. NO. | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT)
RICHARD BRINKLEY EVANS | | | | 2a DATE OF DEATH
DECEMBER 20, 1984 | | 2b HOUR
3:00 P.M. | | | |
| 3 SEX
MALE | | 4 RACE
WHITE | | 5 DATE OF BIRTH
NOVEMBER 13, 1947 | | 6 AGE (IN YEARS LAST BIRTHDAY)
37 YRS. | | 7b HOUR
3:00 P.M. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | | | |
| 10 CITY OR TOWN OF DEATH
BETHESDA | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NIH, THE CLINICAL CENTER | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Pharmacist | | 12b KIND OF BUSINESS OR INDUSTRY
REVCO DRUG CENTER | | | |
| 13a STATE
VIRGINIA | | 13b CITY OR TOWN
MIDLOTHIAN | | 13c INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d STREET ADDRESS / ZIP CODE
630 WATCH HILL ROAD 23113 | | | |
| 14 FATHER'S NAME
CHARLES | | 14b GRAHAM | | 14c EVANS | | 15 MOTHER'S MAIDEN NAME
NELLE | | 15b SIGMAN | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
NO | | 16b SOCIAL SECURITY NO.
231-68-2663 | | 17 INFORMANT
VIRGINIA B. EVANS, WIFE | | 17b ADDRESS (SAME AS PT.) | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>DIFFUSE MIXED LYMPHOMA</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>NOVEMBER 22</u> , 19 <u>83</u> , to <u>DECEMBER 20</u> , 19 <u>84</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>DECEMBER 20</u> , 19 <u>84</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death. | | | | | | | | | |
| 22b SIGNATURE
<i>Sanford Markowitz MD</i> | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
Sanford Markowitz MD | | 22e ADDRESS
NATIONAL INSTITUTES OF HEALTH
BETHESDA, MARYLAND 20205 | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b DATE
12-22-84 | | 23c NAME OF CEMETERY OR CREMATORY
Westhampton Memorial | | 23d LOCATION
CITY OR TOWN COUNTY STATE
Richmond Va. | | | |
| 24 FUNERAL DIRECTOR
NAME
Everly-Wheatley Funeral Home Alex., Va. | | 24b ADDRESS
1500 W. Braddock | | 25a DATE REC'D. BY REGISTRAR
DEC 24 1984 | | 25b REGISTRAR'S SIGNATURE
<i>Julia Davidson</i> | | | |

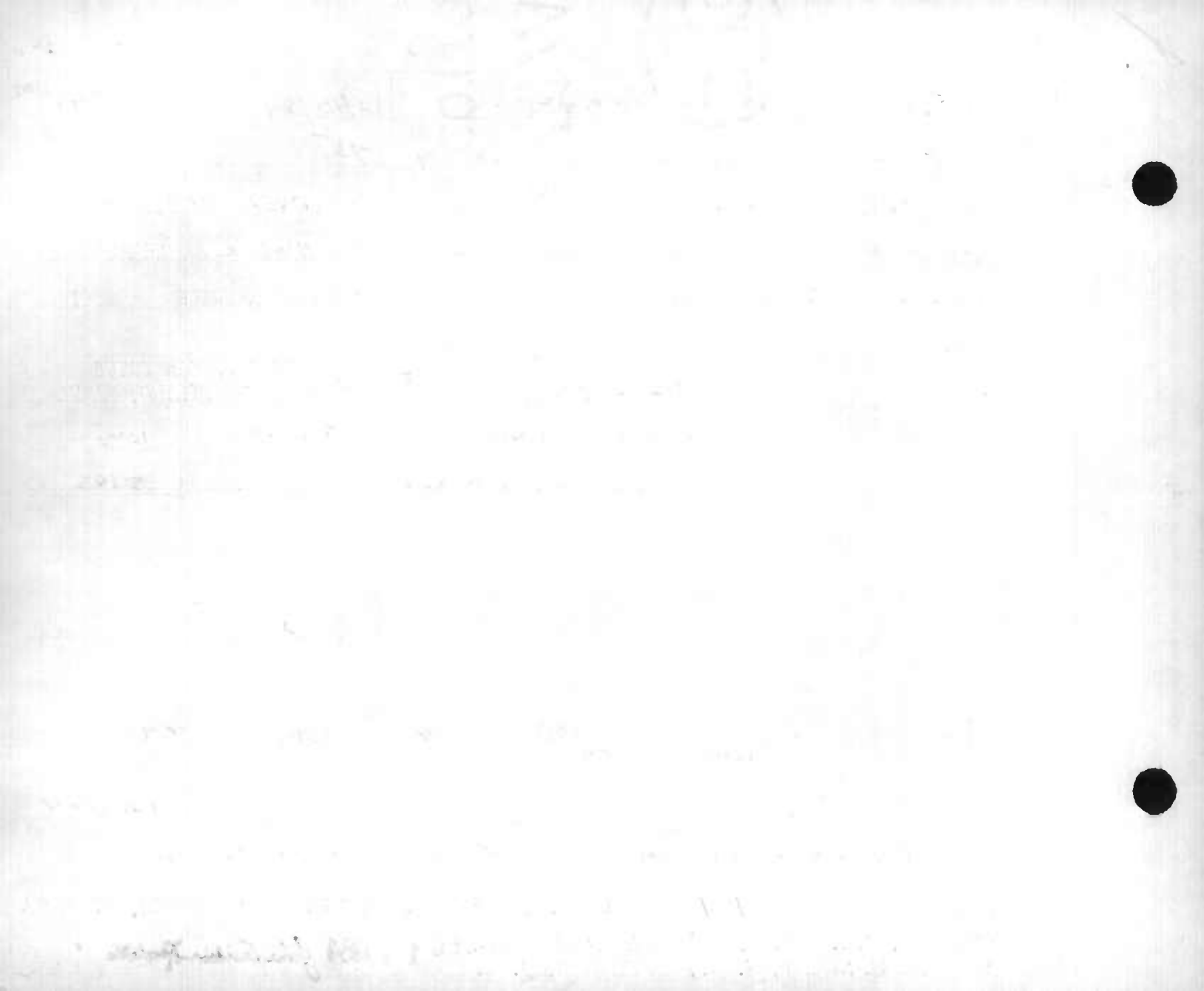


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 33952
REG. NO. | | |
|---|--|---|--|---|--|---|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
ESTELLE FAIRBERG | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/10/84 | | | | 2b. HOUR
5:45 PM | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 28 09 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS HOSPITAL | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SECRETARY | | 12b. KIND OF BUSINESS OR INDUSTRY
LEGAL | | |
| 13a. STATE
MARYLAND | | | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2221 OSBORN DRIVE 20910 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILLIAM BARWESS | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
BECKIE | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | | 16b. SOCIAL SECURITY NO.
080-10-0008A | | 17. INFORMANT
RAYMOND FAIRBERG, 2221 OSBORN DRIVE, SILVER SPRING, MARYLAND | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-Respiratory Failure | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 hour | | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) Eutectic Calcium | | | | | | | | | | 5:125 | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
12/10 84 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
8630 FENIX ST. FALLS CHURCH, VIRGINIA | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/10 84 to 12/10 84 , that (I) (we) last saw the deceased alive on 12/10 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
S. S. Goin | | | | | | DEGREE
M.D. | | | | 22c. DATE SIGNED
12/10/84 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
EDGAR H. LEVIN | | | | | | 22e. ADDRESS
8630 FENIX ST. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | | | 23b. DATE
12/13/1984 | | 23c. NAME OF CEMETERY OR CREMATORY
KING DAVID MEMORIAL | | | | 23d. LOCATION
GARDEN TOWNSHIP FALLS CHURCH, VIRGINIA | | |
| 24. FUNERAL DIRECTOR
NAME
DONALD M. STEIN | | | | | | 24b. ADDRESS
HEBREW MEMORIAL FUNERAL HOME | | | | 24c. DATE RECEIVED BY REGISTRAR
12/17/84 | | |
| 25. REGISTRAR'S SIGNATURE
John L. ... | | | | | | | | | | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 3 9 5 3
REG. NO.1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | |
|--|--|---|--|---|--|---|---|---|--|---|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Eager J. Fannon</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>December 11, 1984</i> | | | 2b. HOUR
<i>5:10 PM</i> | | | | | | |
| 3. SEX
<i>M</i> | | 4. RACE
<i>W</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>3 12 15</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>69</i> YRS | | | | | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
<i>MARYLAND</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>MONTGOMERY</i> MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>SILVER SPRING</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>HOLY CROSS HOSPITAL</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>SALESMAN</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>PRUDENTIAL INSURANCE</i> | | | | |
| 13a. STATE
<i>MARYLAND</i> | | | 13b. COUNTY
<i>MONTGOMERY</i> | | 13c. CITY OR TOWN
<i>SILVER SPRING</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<i>9510 COLUMBIA BLVD. 20910</i> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>MICHAEL FANNON</i> | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>FARRELL</i> | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>YES</i> | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<i>WW II</i> | | 17. INFORMANT
<i>SON</i> | | ADDRESS
<i>9013 MILES STREET</i> | | 17. INFORMANT
<i>JAMES E. FANNON</i> | | ADDRESS
<i>SILVER SPRING, MD. 20901</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>cardiac arrest</i>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>Subdiaphragmatic abscess</i> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/11</i> , 19 <i>84</i> , to <i>12/11</i> , 19 <i>84</i> , that (I) (we) lost
saw the deceased alive on <i>12/11</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Bernard A. Heckman, M.D.</i> | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>BERNARD HECKMAN</i> | | | 22e. ADDRESS
<i>SILVER SPRING MARYLAND</i> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>BURIAL</i> | | | 23b. DATE
<i>12/15/84</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>OLD ST. JOHNS</i> | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>FOREST GLEN MONT MD.</i> | | | | |
| 24. FUNERAL DIRECTOR
NAME
<i>FRANCIS J. COLLINS</i> | | | | | | ADDRESS
<i>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>DEC 17 1984</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

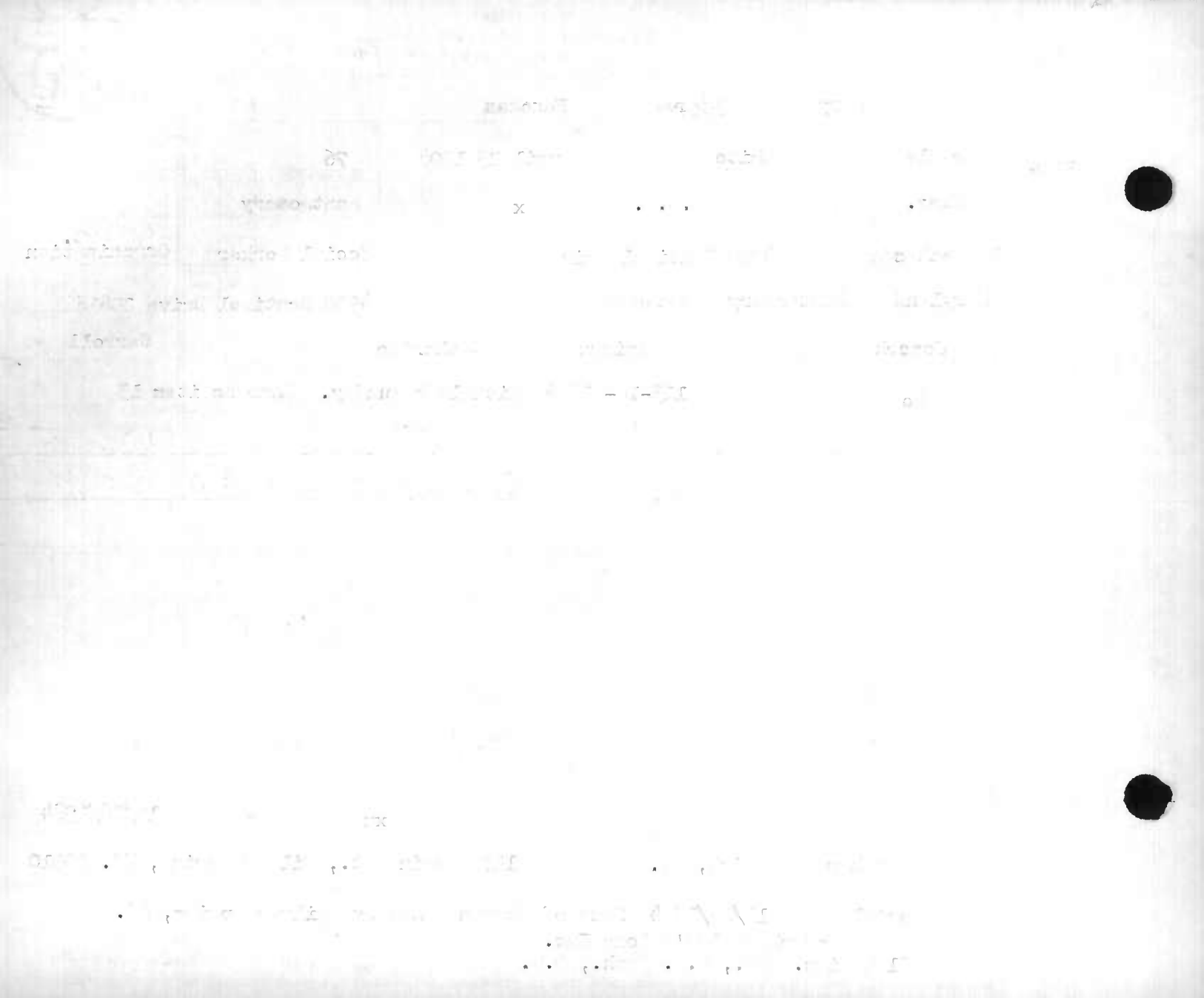
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 3 9 5 4
REG. NO.

| | | | | | |
|---|---|---|--|--|---|
| FOR
1. STATE REGISTRAR | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | 3 3 9 5 4
REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Mary Spiers Fazekas | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 26 84 | | 2b. HOUR
MIN.
9 54 AM |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
April 25 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Mass. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4920 Sentinel Drive | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Social Worker | | 12b. KIND OF BUSINESS OR INDUSTRY
Pvt. Organization |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Bethesda | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Spiers | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Katherine Carroll | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
113-16- 1894 | | 17. INFORMANT
ADDRESS
Michele F Munday. Same as item 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis & hypertensive HD
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
25 yrs. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1957 19 12/18 19 84 , that (I) (we) last saw the deceased alive on 12/18 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Abraham W Danish, Md. | | DEGREE
MD | | 22c. DATE SIGNED
12/26/1984 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Abraham W Danish, Md. | | 22e. ADDRESS
1106 Spring St., Silver Spring, Md. 20910 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/28/1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring, Md. | | 24. FUNERAL DIRECTOR
NAME ADDRESS
Joseph Gawler's Sons Inc.
5130 Wisc. Ave., N.W. Wash., D.C. | | | |
| 25a. DATE REC'D. BY REGISTRAR
DEC 31 1984 | | 25b. REGISTRAR'S SIGNATURE
a Davidson-Randall | | | |

MEDICAL CERTIFICATION



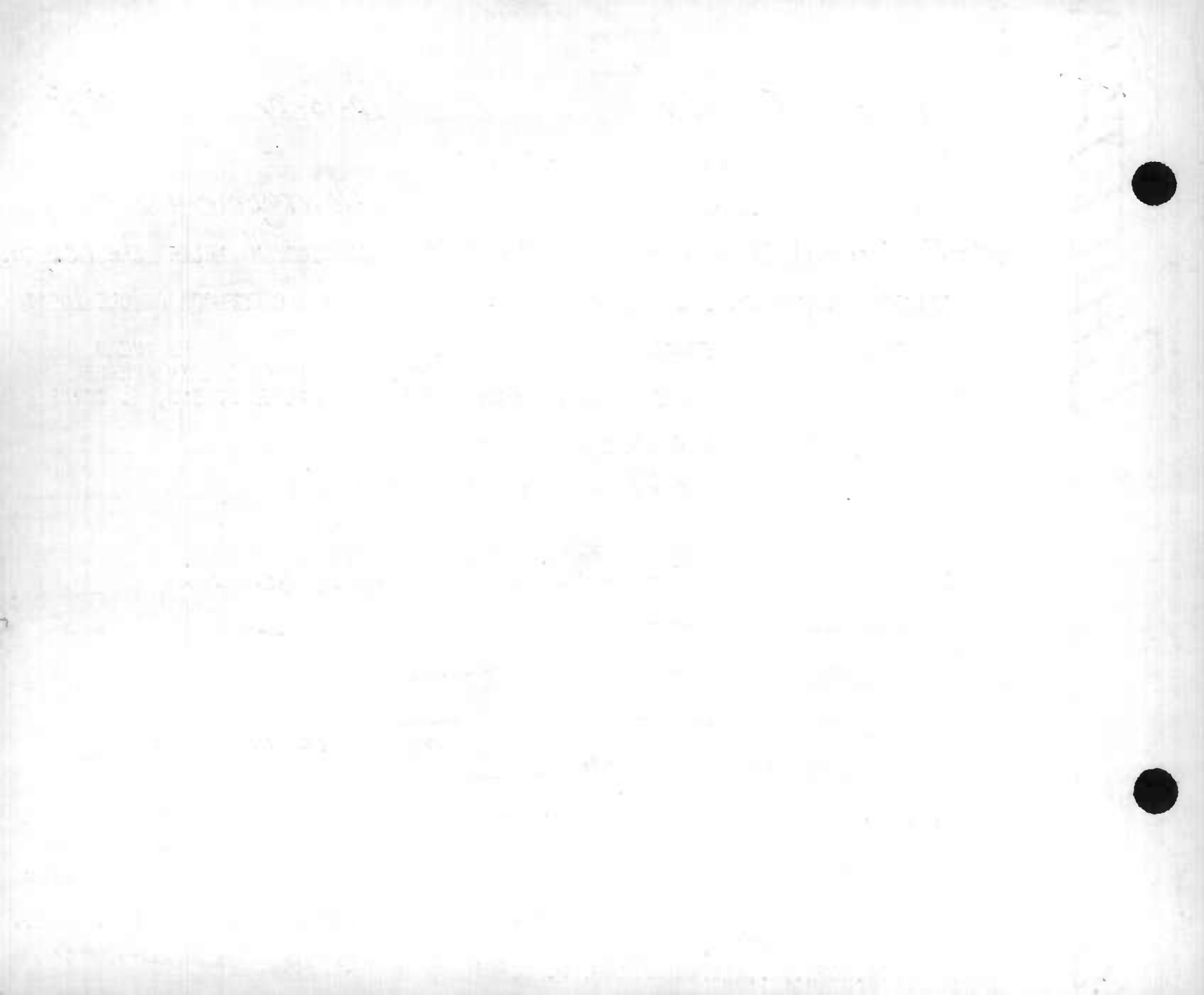
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH33955
REG. NO.1- FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
DAN Fearon | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-15-84 | | | 2b. HOUR
8:45 M | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
MAY 10, 1891 | | 6. AGE (IN YEARS LAST BIRTHDAY)
93 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
IRELAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SERVICEMAN | | 12b. KIND OF BUSINESS OR INDUSTRY
BECKER ELECTRIC CO. | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
FELIX FEARON | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY McGIVERN | | 13e. STREET ADDRESS / ZIP CODE
205 CRESTMOOR CIRCLE 20901 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
577-26-0522 | | 17. INFORMANT
NANCY YOUNG | | ADDRESS
10808 LORAIN AVENUE
SILVER SPRING, MD. 20901 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC failure
DUE TO, OR AS A CONSEQUENCE OF
(b) coronary thrombosis
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
ESOPHAGEAL STRICTURE with esophageal bleeding | | | | | | | |
| 19a. DATE OF OPERATION
____ | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
____ | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
____ P.M. ____ 19 ____ | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
____ | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> AT HOME <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
____ | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
____ | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1979 to 12-15 , 19 84 , that (I) (we) lost
saw the deceased alive on 12-15 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above; (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Roland Imperial | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12-16-84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROLAND IMPERIAL | | 22e. ADDRESS
4977 BATTERY LANE BETHESDA MD 20814 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12/19/84 | | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
SILVER SPRING MONT MD. | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 19 1984 | | | |
| 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

33956
REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MARGARET G. FELLER | | | 2a. DATE OF DEATH
MONTH December DAY 7 YEAR 1984 | | | 2b. HOUR
10:25PM | | | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH September DAY 30 YEAR 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 8. IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Canada | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hospital | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Nurse | | 12b. KIND OF BUSINESS OR INDUSTRY
Health care | |
| 13a. STATE
New York | | | | 13b. CITY OR TOWN
Orleans | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE
310 Eagle Street 14103 | | | |
| 14. FATHER'S NAME
FIRST Wilfred MIDDLE G. LAST Bailey | | | | 15. MOTHER'S MAIDEN NAME
FIRST Mary MIDDLE E. LAST O'Reilly | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO.
081-32-0462 | | 17. INFORMANT Mrs. John Rouse ADDRESS 75 Orchard Drive Gaithersburg, Md. 20878 | | | | | |

| | | | |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1-2 wks | |
| DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | (b) | |
| DUE TO, OR AS A CONSEQUENCE OF | | (c) | |

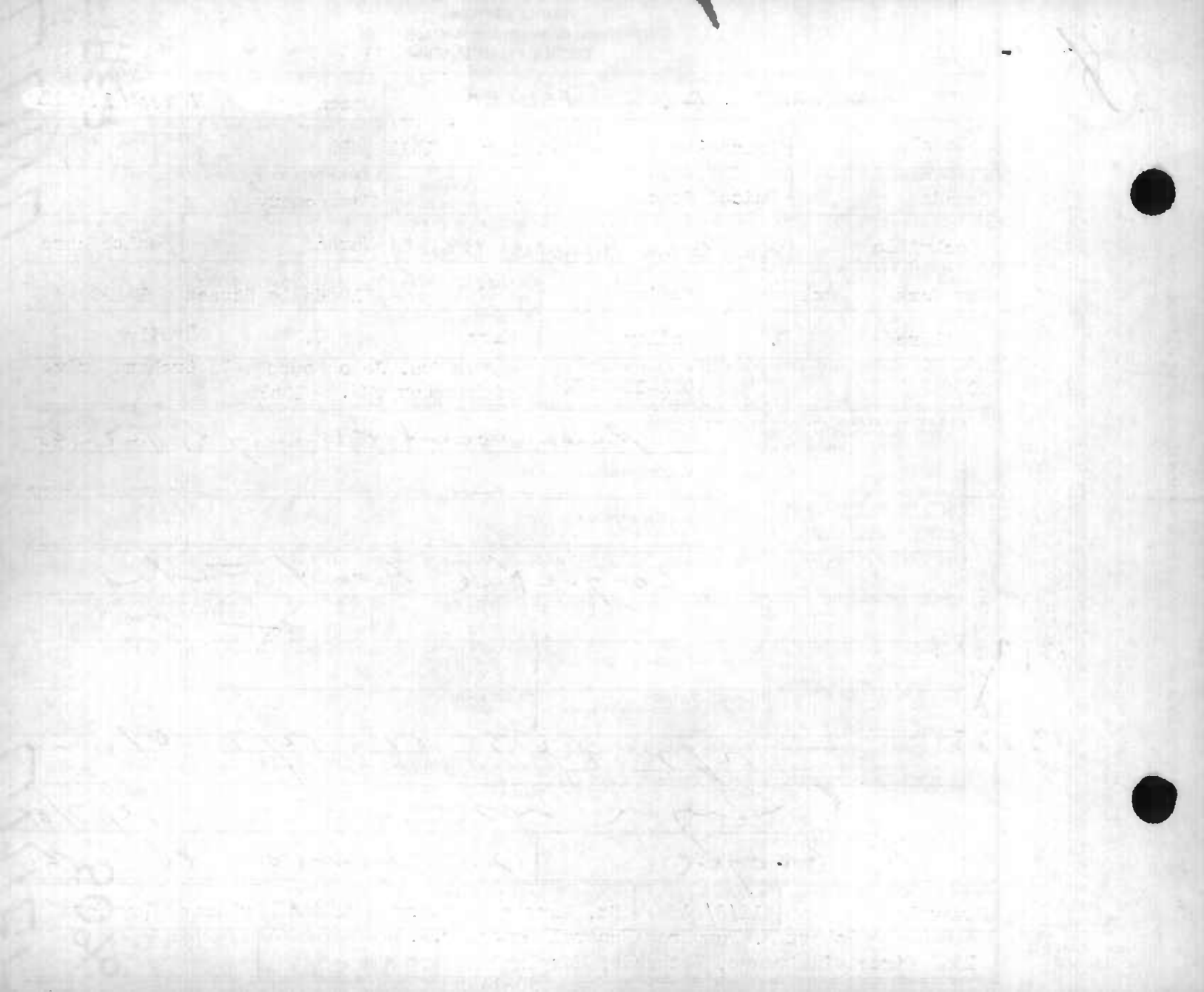
| | | | | | | | |
|--|--|--|--|--|--|--|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Coronary Heart Failure | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 8/3/84 to 12/7/84 , that (I) (we) last saw the deceased alive on 12/7/84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
R. Grege | | | | DEGREE MD
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/7/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
R. Grege | | | | 22e. ADDRESS
1205 Carverstown Rd Gaithers. | | | |

| | | | | | | | |
|--|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Removal | | 23b. DATE
12/8/84 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Mary's Cemetery | | 23d. LOCATION
CITY OR TOWN Medina COUNTY Orleans STATE New York | |
| 24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P.A. | | | | | | 25. REGISTRAR'S SIGNATURE
Davidson-Randall | |
| 7557 Wisconsin Avenue, Bethesda, Maryland | | | | | | DEC 11 1984 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or has US stamp any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low required that the death certificate be associated within 20 days after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of page 47.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 33957 | |
|---|---|--|---|---|--|--|-----------------------------------|---|------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | |
| PAUL | | T. | | FENTON Sr. | DEC. | | 18 | 1984 | | 2:01 PM | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | |
| MALE | White | | 11 23 08 | | 76 | | MONTHS DAYS | | HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| Wash.D.C. | USA | | | | MONTGOMERY MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | | | 12a. USUAL OCCUPATION
(TYPE OR WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| SILVER SPRING | HOLY CROSS HOSPITAL | | | | Wash.Daily News Retired | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | | | | | | | |
| MARYLAND | MONTGOMERY | SILVER SPRING | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 9039 5460 Hwy #1505/20901 | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| Matthew | | Elizabeth V. Lynch | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT | | | | | | | |
| None | | 578-07-748 | | 14805 Maydale Court, S.S.Md.
Paul T.Fenton, Jr. (Son) 20904 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL DISEASE</u> | | | | | | | | | | 30 MINUTES | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) <u>CHRONIC MYOCARDIAL DISEASE</u> | | | | | | | | | | YEARS | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>DEC 18</u> , 19 <u>84</u> , to <u>DEC 18</u> , 19 <u>84</u> , that (I) (we) last
saw the deceased alive on <u>DEC 18</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Peter R Hammond</u> | | | | DEGREE
MD | | | | 22c. DATE SIGNED
<u>Dec 18, 1984</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>PETER R HAMMOND</u> | | | | 22e. ADDRESS
<u>HOLY CROSS HOSPITAL
SILVER SPRING MD</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(CHECK ONE) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| Cremation | | 12/19/84 | | Lee's Crematory | | Wash.D.C. | | | | | |
| 24. FUNERAL DIRECTOR
NAME <u>Hines/Rinaldi</u> ADDRESS <u>11800 New Hamp.Ave.S.S.Md</u> | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
<u>Reha Davidson-Randall</u> | | | |
| | | | | | | DEC 21 1984 | | | | | |

BP



Handwritten text, possibly a date or initials, located in the upper left quadrant of the page.

Handwritten text, possibly a date or initials, located in the lower left quadrant of the page.

Handwritten text, possibly a date or initials, located in the lower left quadrant of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 3 9 5 8

| | | | | | | | | | |
|---|--|--|--|---|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Stephen J. Ferko | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 21, 1984 | | | 2b. HOUR
11:10 AM | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Nov. 25 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New Jersey | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
US Metals Crane Operator | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
Olney | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
18421 Wocho Terrace 20832 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Stephen Ferko | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Julia UNK | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
145 09 5773 | | 17. INFORMANT
ADDRESS
Marion Ferko (Wife) Same as 13E | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bronchogenic carcinoma</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
18 mo | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Lymph node metastasis. Possible liver & brain metastasis. ASHD.</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>84</u> , to <u>21 Dec</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>21 Dec</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Donald E. Dillon</u> MD | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
21 Dec 84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Donald E. Dillon, M.D. | | | | | | 22e. ADDRESS
2901 Olney - Sandy Spring Rd
Olney, Md 20832 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
12/27/84 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Gertrude Cemetery Colonia, New Jersey | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| 24. FUNERAL DIRECTOR
NAME
Hines/Rinaldi 11800 New Hamp. Ave. S.S. Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 24 1984 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| FOR STATE REGISTRAR | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 33959
REG. NO. | | | |
|--|--|---|--|---|--|---|--|--|--|-----------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Jessie E. Finlay | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12 30 84 | | | | 2b. HOUR
2:52 P.M. | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
10 07 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY)
89 YRS | | 7. UNDER 1 YEAR MONTHS DAYS
89 | | 7. UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR ACADEMIC OF WORKING LIFE)
housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
home | | | |
| 13a. STATE
MD | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
261 Congressional Lane Apt 605 20854 | | | |
| 14. FATHER'S NAME
Paul MIDDLE Hansch | | | | 15. MOTHER'S MAIDEN NAME
Josephine MIDDLE Seman LAST | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
060 01 6889 | | 17. INFORMANT
John Finlay | | ADDRESS
2440 N. Virginia Ave NW Wash DC | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF THE COLON
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 MONTHS | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CONTRIBUTING TO DEATH</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION
11-29-84 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
BLEEDING FROM RIGHT COLON CANCER | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21i. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/29/84 19 to 12/30/84 19, that (I) (we) last saw the deceased alive on 12/30/1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
J. Goicochea | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12/30/84 | | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
J. GOICOCHEA | | | | 22e. ADDRESS
8512 OLD GEORGETOWN Rd, BETHESDA, MD 20814 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | 23b. DATE
Jan. 4, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Long Island Cemetery National | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Pinelawn, New York | | | | | |
| 24. FUNERAL DIRECTOR NAME
Ives-Pearson Funeral Homes
Arlington, Va. 22201 | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 9 1985 | | 25b. REGISTRAR'S SIGNATURE
John Davidson | | | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Postmortem may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 33960
REG. NO. | |
|--|--|---|--|---|---|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Mabel Marie Fleming | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 20 84 | | | 2b. HOUR
12³⁰ AM | | | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
OCT. 6. 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
84 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ILLINOIS | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
9905 Markham Street | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
FED. GOVT. (RET) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
MD | | | 13b. COUNTY
MONT. | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
8505 SPRINGDALE TERRACE 20910 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ARAIN J. HARBERS | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
JOHANN DISTLER | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
217 14 7207 | | 17. INFORMANT ADDRESS
EDWARD J. FLEMING, JR. 9905 MARKHAM ST | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic carcinoma
DUE TO, OR AS A CONSEQUENCE OF
(b) Carcinoma of the colon
DUE TO, OR AS A CONSEQUENCE OF
(c) NO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
WKS. TO MS.
NO | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 10 1984 to Dec 20 1984 , that (I) (we) lost saw the deceased alive on Dec 16 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Albert H. Gullman MD. | | | | | | DEGREE
MD. | | 22c. DATE SIGNED
12/20/84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Albert H. Gullman MD. | | | | | | 22e. ADDRESS
1106 Spring St. Silver Spring Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | | | 23b. DATE
DEC. 22, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
FORT LINCOLN CREMATORY | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BRENTWOOD MD | | | |
| 24. FUNERAL DIRECTOR
NAME
Takoma Funeral Home | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 24 1984 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randell | | | |
| 25c. ADDRESS
254 Carroll St. NW Washington, D. C. | | | | | | | | | | | |

BP

Page 10

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH33961
REG. NO.FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Oscar Thomas Fraley, Jr | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 30 84 | | | 2b. HOUR
2A M | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 19 30 | | 6. AGE (IN YEARS LAST BIRTHDAY)
54 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
US | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Elec. Motor rep. | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Oscar Thomas Fraley, Sr. | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary V. Aeder | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE SERVICE OR DATES)
yes Korea | | | |
| 16b. SOCIAL SECURITY NO.
213243622 | | 17. INFORMANT
ADDRESS
Norma V. Fraley same as 13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sepsis
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Granulocytosis
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 day
4 day | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
COPD Chronic Renal Failure | | | | | | | |
| 19a. DATE OF OPERATION
12/27 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
12/27 | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/27 19 84 , to 12/30 19 84 , that (I) (we) last saw the deceased alive on 12/25 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Raymond B. BBS | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12-30-84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RAYMOND BBS | | 22e. ADDRESS
3929 Furlow Dr. Wheaton Md 20906 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1/2/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Memorial Park | | 23d. LOCATION
CITY OR TOWN STATE
Rockville, Maryland | |
| 24. FUNERAL HOME OR OTHER INSTITUTION
NAME ADDRESS
Tyson Wheeler Funeral Home, Inc.
1331 Rockville Pike, Rockville, Md. 20852 | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 7 1985 | | | |
| 25b. REGISTRAR'S SIGNATURE
J. H. Davidson-Randall | | | | | | | |

12H

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

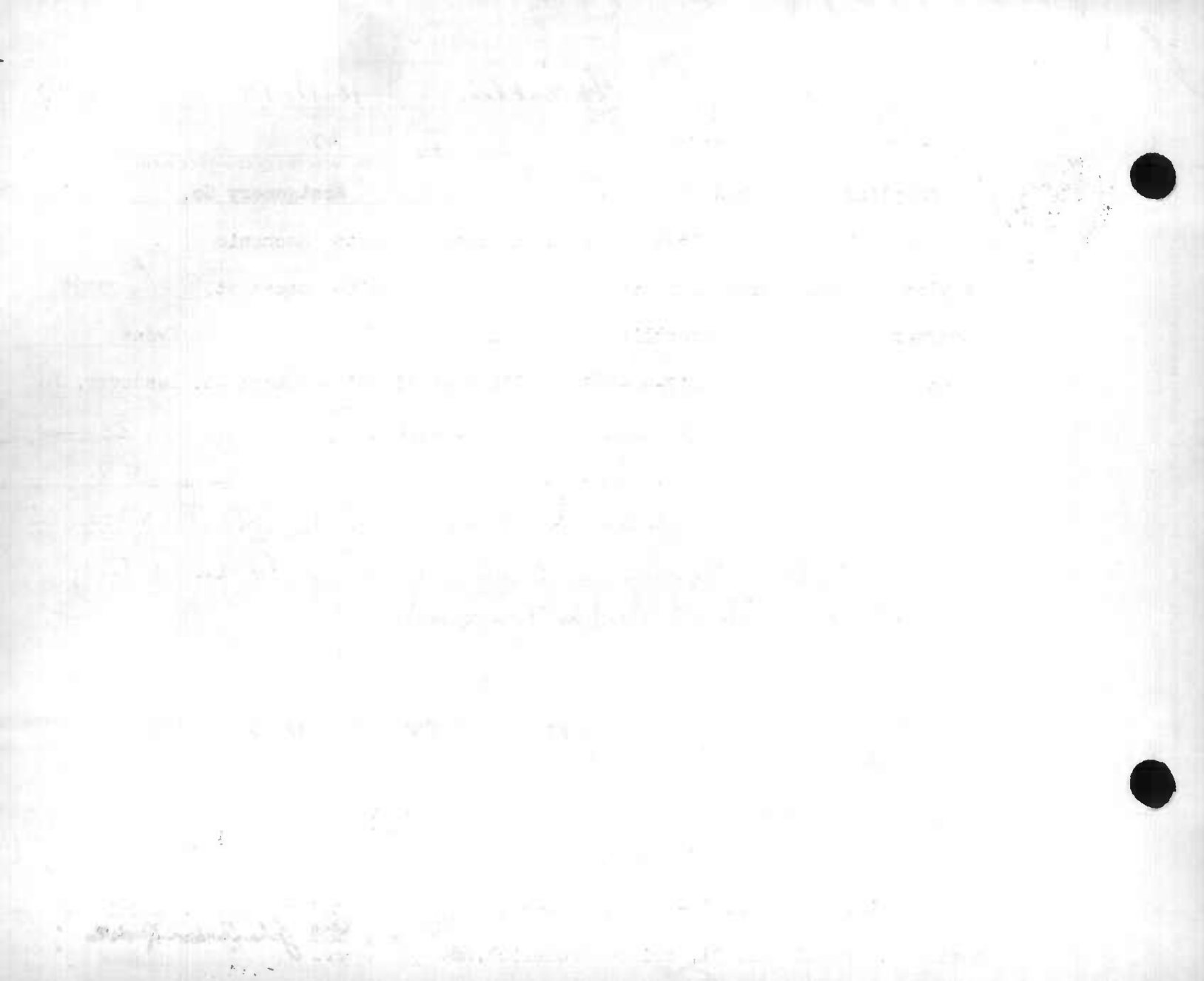


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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| FOR
1- STATE
REGISTRAR | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 3 3 9 6 2
REG. NO. | | | | | | |
|--|---------|--|--------------------------|--|------|---|--|--------------------------------|-----------------------------------|------------|------|----------|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | | MONTH | DAY | YEAR | 2b. HOUR |
| James Franklin | | | | | | 12-12-84 | | | | | | 11:15 PM |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | |
| Male | Black | 2 21 44 | | 40 | | MONTHS | | DAYS | | HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| Maryland | | USA | | | | Montgomery Co. MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Takoma Park | | Washington Adventist Hosp. | | | | Auto Mechanic | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | | |
| Maryland | | Pr. George | | Landover | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 9104 Hobert St. | | 20785 | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| Sherman Franklin | | | Ada Evans | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | |
| no | | 217-42-8678 | | Ella Franklin | | 9104 Hobert St. Landover, Md | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Cad. Arter</u> | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arter</u> | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Endocardial Tube Dis. by Dist. 5-10</u> | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Metastatic Sp. Cell Carcinoma to Liver + Lung</u> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| 11-28-84 | | Rule out Card. in T. Amp. Arter | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | | | | |
| WHILE <input type="checkbox"/> AT WORK | | | | STREET | | CITY OR TOWN COUNTY STATE | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>11-28-84</u> to <u>12-12-84</u> , that (I) (we) last saw the deceased alive on <u>12-11-84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22a. SIGNATURE | | 22b. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22c. ADDRESS | | 22d. DATE SIGNED | | | | | | |
| <u>Paul D. Kierulff, M.D.</u> | | Paul D. Kierulff, M.D. | | 831 University Boulevard West Silver Spring, Md | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | | |
| Burial | | Dec. 15-84 | | Moses Cemetery | | CITY OR TOWN | | COUNTY STATE | | | | |
| | | | | | | Lothian | | Anne Arundel Md | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | | | |
| NAME ADDRESS | | | | | | | | | | | | |
| Spencer E. Sewell Box 31, Prince Frederick, Md | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) CARRIE P. Freeman | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 16 84 | | | 2b. HOUR
MIN.
943 A | | | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
June 21, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 8. IF UNDER 24 HRS
HOURS MIN. | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Connecticut | | 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | 12. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1220 East West Highway, # 512 20910 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Edward N. Parkus | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Charlotte Hodge | | | | 16. INFORMATION ADDRESS
Severn, Maryland 21144 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
577-42-8299 | | 17. INFORMANT
Donald P. Freeman, son, 1392 Teaberry Lane, | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of the Lung
DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from August 83 , 19 83 , to December , 19 84 , that (I) (we) lost saw the deceased alive on _____, 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Hector K. Collison | | | | 22c. DATE SIGNED
12/16/84 | | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HECTOR K. COLLISON | | | |
| 22e. ADDRESS
1111 Spring St - Silver Spring | | | | 22f. DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(CHECK ONE)
Burial | | | | 23b. DATE
Dec. 19, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Rock Creek | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D. C. | | | |
| 24. FUNERAL DIRECTOR
NAME
McGuire Funeral Service, Inc. | | | | 24b. ADDRESS
7400 Georgia Ave. NW, Washington, DC 20001 | | | | 25. DATE REC'D. BY REGISTRAR
DEC 24 1984 | | | |
| 25. REGISTRAR'S SIGNATURE
John K. ... | | | | | | | | | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 33964 | | | | | | | |
|--|--|--|---|---|--|---|--|--|--|--|--|---|--|-------------------------------|--|-------------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | | 1. DECEASED NAME FIRST MIDDLE LAST
Walter George Frye, Jr. | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
11/28/84 | | | | 2b. HOUR
0225 ^M | |
| 3. SEX
Male | | | 4. RACE
Black | | | 5. DATE OF BIRTH MONTH DAY YEAR
December 16, 1916 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS | | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Gaithersburg | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Laborer | | | 12b. KIND OF BUSINESS OR INDUSTRY
Railroad | | | | | |
| 13a. STATE
Pennsylvania | | | 13b. COUNTY
13c. CITY OR TOWN
Philadelphia | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS
2047 Catherine Street | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Walter G. Frye, Sr. | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary (Information not available) | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | | | | | 16b. SOCIAL SECURITY NO.
147-01-4146 | | | 17. INFORMANT ADDRESS
Dorothy Frye, wife, same address | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>MESENTERIC THROMBOSIS</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 week</u> | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 15</u> , 19 <u>84</u> , to <u>Nov 28</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>Nov 27</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u> | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
11/28/84 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Stephen Hellman MD | | | | | | 22e. ADDRESS
6246 Montrose Rd Rockville MD | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
Dec. 4, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Merion | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Cynwyd, Pennsylvania | | | | | | | |
| 24. FUNERAL DIRECTOR
McGuire Funeral Service, Inc., 7400 Georgia Ave., Washington, DC | | | | | | | | | | | | | | | | | |
| 25. DATE REC'D BY REGISTRAR
DEC 06 1984 | | | | | | | | | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | | | | | | | | | | | | | | | |

(A)

100% COTTON
JANUARY

52

1918

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 33965 | | | |
|---|--|--|--|---|--|---|--|--|--|--|-----|-----------------------|----------|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| BEATRICE | | | | | | FULTON | | 11 | | 29 | 84 | 10 ³⁰ P.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| FEMALE | | B | | MONTH DAY YEAR
6 3 13 | | 71 YRS. | | MONTHS DAYS | | HOURS MIN. | | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
TAKOMA PARK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
WASHINGTON ADVENTIST HOSPITAL | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY
FED. GOVERNMENT | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | |
| 13a. STATE
MD. | | 13b. COUNTY
MC | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
8750 GEORGIA AVE. 20910 | | | | | |
| 14. FATHER'S NAME
WHITTAKER FULTON | | | | | | 15. MOTHER'S MAIDEN NAME
ADA HAZLIP | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
578-20-1324 | | 17. INFORMANT ADDRESS
EDITH EDWARDS-4407 17TH. ST., N.W. WASH., D.C. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardio Respiratory ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Hypertension c. Metastasis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Arteriosclerotic heart c. Heart failure</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (d) | | | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-27-</u> 19 <u>84</u> to <u>11-29-</u> 19 <u>84</u> that (I) (we) last saw the deceased alive on <u>11-29-</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Tony P. Kannarkat | | | | DEGREE
MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
11/30/84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
TONY P. KANNARKAT, MD | | | | | | 22e. ADDRESS
8201 16th ST S.S. MD 20910 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | | 23b. DATE
12/5/84 | | 23c. NAME OF CEMETERY OR CREMATORY
LINCOLN MEMORIAL | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
SUITLAND, MD. | | | |
| 24. FUNERAL DIRECTOR
NAME MORROW & WOODFORD, INC. ADDRESS
1622 11TH. ST., N.W. WASH., D. C. 20001 | | | | | | | | | | | | | |

DEC 13 1984



FOR
1 - STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 3 3 3 3 3
REG. NO.

| | | | | | | | | | | |
|--|--|---|---|---|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Naomi S. Fultz | | | 2a. DATE OF DEATH MONTH DAY YEAR
December 20, 1984 | | | 7b. HOUR
7⁴⁵ A M | | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 9, 1888 | | 6. AGE (IN YEARS LAST BIRTHDAY)
96 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Kensington | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Kensington Gardens Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
4620 N. Chelsea Lane / 20814 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Uriah David Seltzer | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Barbara Elizabeth Light | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
577-07-0331 | | 17. INFORMANT ADDRESS
Mr. Charles D. Fultz, Son, Same as item #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Terminal ventricular arrhythmia
DUE TO, OR AS A CONSEQUENCE OF
(b) Coronary heart disease
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
instant
year | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:
Chronic organic brain syndrome | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from April 15, 1983 to 12/20, 1984 , that I (we) last saw the deceased alive on 12/20, 1984 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, I (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Martin C. Shargel | | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
December 20, 1984 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Martin C. Shargel, M.D. | | | 22e. ADDRESS
3720 Farragut Avenue
Kensington, Maryland 20895 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | 23b. DATE
(SPECIFY)
December 20, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria, Virginia | | | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland | | | 25a. DATE REC'D. BY REGISTRAR
DEC 24 1984 | | 25b. REGISTRAR'S SIGNATURE
John A. ... | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 33961 | | | | |
|--|--|---|---|--|---|--|--|---------------------|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Grace E. Funk | | | | 2a. DATE OF DEATH MONTH DAY YEAR
December 10 1984 | | | | 2b. HOUR
11:31AM |
| 3. SEX
Female | 4. RACE
Cauc. | 5. DATE OF BIRTH MONTH DAY YEAR
April 2 1889 | | 6. AGE (IN YEARS LAST BIRTHDAY)
95 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Kansas | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Agriculture | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Govt. | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Mont. | 13c. CITY OR TOWN
Kensington | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
10231 Carroll Place 21157 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Wm. D. Dodson | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Amanda Slone | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
579-60-5539 | | 17. INFORMANT ADDRESS
LaVerne Jetter 250 E. Alameda Dr. Sante Fe., N. Mex. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO SCLEROTIC HEART DISEASE
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7 YR | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: HYPERTENSION | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) the deceased attended the deceased from MAR 21, 1977 to DEC. 10, 1984 , that (I) was last saw the deceased alive on DEC 6, 1984 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (If I was not did not see the body after death.) | | | | | | | | |
| 22b. SIGNATURE
<i>William S. Miller M.D.</i> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/10/84 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
William S. Miller M.D. | | | | 22e. ADDRESS
4201-Conn. Ave N.W. WASH D.C. 20008 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
Dec. 11, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria, Virginia | | |
| 24. FUNERAL DIRECTOR NAME
<i>John F. DeVol</i>
DeVol Funeral Home, Inc., 2222 Wisc. Ave., NW., Wash. DC | | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

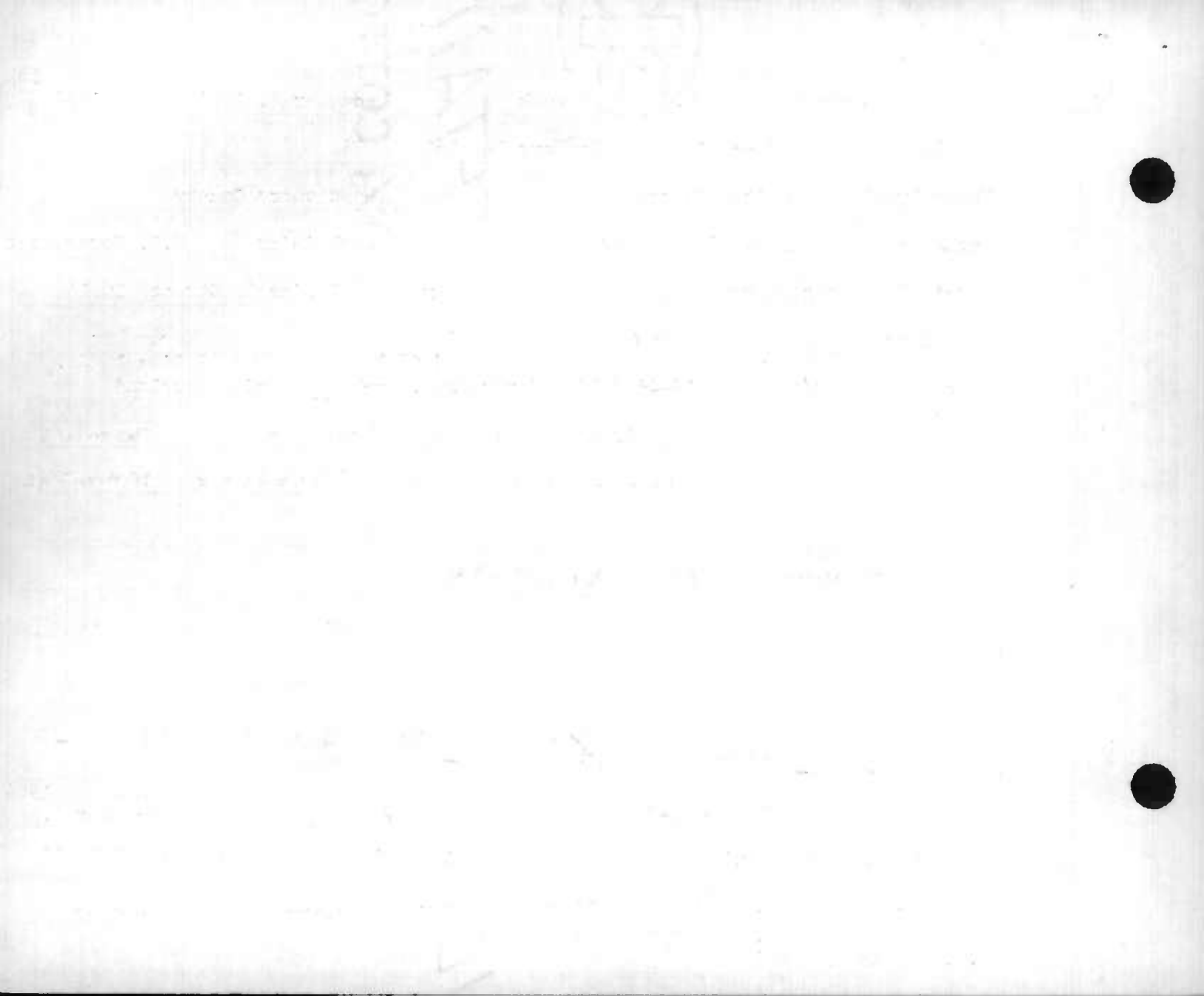
BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|--|------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Raymond E. Funk | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 4, 1984 | | | 2b. HOUR
am
1:56 | | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
January 14, 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5607 Lincoln Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Bookbinder | | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Government | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
5607 Lincoln Street 20814 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Amos Funk | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Annie Newcomber | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | | 17. INFORMANT (Wife)
Gertrude E. Funk, Bethesda, Maryland | | ADDRESS 5607 Lincoln St. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Myxoid Heart Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>30 mins.</u>
<u>10 months.</u> | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
<u>Carcinoma of Prostate.</u> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 1</u> , 19 <u>83</u> , to <u>Dec 4</u> , 19 <u>84</u> , that (I) () lost
saw the deceased alive on <u>Dec 2</u> , 19 <u>84</u> , and that in (my) () opinion death occurred on the date and hour and from the causes stated
above, (I) () (did) () view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>John F. Tauber</u> MD | | | | | | DEGREE
MD | | 22c. DATE SIGNED
December 4, 1984 | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John F. Tauber M.D. | | | | | | 22e. ADDRESS
8218 Wisconsin Avenue, Bethesda, MD 20814 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
December 5, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft Lincoln Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes,
NAME P.A. Bethesda, Maryland ADDRESS | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 7 1984 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson-Randall</u> | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| items 1 & 17 1/2-5 mth F#599 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 33969
REG. NO. | | | |
|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Eileen T. Garfinkle | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR Dec. 14, 1984 | | | | 2b. HOUR
5:00a M | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR Jan. 23 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Mass. | | 7b. CITIZEN OF WHAT COUNTRY?
USA. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
11116 Whisperwood Lane | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Paralegal | | 12b. KIND OF BUSINESS OR INDUSTRY
Law Firm | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
11116 Whisperwood Lane 20852 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Louis Tekley | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bessie Shandler | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
011 18 6154 | | 17. INFORMANT
ADDRESS
Garfinkle
Stuart Garfinkel-See #13 above | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) metastatic lung cancer | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
4 mos. | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
DUE TO, OR AS A CONSEQUENCE OF (b) lung cancer
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | 10 mos. | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from Aug 30 , 19 84 , to Dec. 12 , 19 84 , that (b) (we) last saw the deceased alive on Dec. 3 , 19 84 , and that in (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above (If (b) is solid (did not) see the body after death). | | | | | | | | | | | | | |
| 22b. SIGNATURE
Phillip Cohen | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/14/84 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Phillip Cohen, M.D. | | | | | | 22e. ADDRESS
2150 Penn. Ave, N.W. Suite 619 Wash, D.C. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Dec. 17 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Judean Mem'l Gardens | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Olney, Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Iyes-Pearson Funeral Homes, Arlington, Va. | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
Julia K. ... | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 33970
REG. NO. | |
|--|--|---|---|---|--|---|---|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
SNOWIE A GARRETT | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12-29-1984 | | | 2b. HOUR MIN.
3:35 P.M. | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
August 6 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | | # UNDER 1 YEAR
MONTHS DAYS | | # UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington DC | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Book Binder | | 12b. KIND OF BUSINESS OR INDUSTRY
Private Printing | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Mont | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
199 Rollins Ave 20852 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
George F. Garrett | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Florrie A. Bushong | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
-- | | 17. INFORMANT
John G. Lambden | | 17a. ADDRESS
771/2 Maryland Ave Annapolis, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic - respiratory failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Cardiac embolism
DUE TO, OR AS A CONSEQUENCE OF
(c) Sudden Atherosclerotic Spontaneous | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days
20 yrs
35 yrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov , 19 84 , to 29 Dec , 19 84 , that (I) (we) last saw the deceased alive on 29 Dec , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If so, I) (we) did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Dr. W. H. H. H. H. | | | | DEGREE
MD | | | | 22c. DATE SIGNED
12/29/84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. W. H. H. H. H. | | | | 22e. ADDRESS
7801 Montell Ave Bethesda Md 20814 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
2 Jan 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cem | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood PG Md | | | | |
| 24. FUNERAL DIRECTOR
NAME
Robert E. Wilhelm Funeral Home | | | | ADDRESS
Suitland, Md | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
JAN 9 1985 John Davidson | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1- FOR STATE REGISTRAR | | Paul H. Gaver | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | 3 3 9 7 1
REG. NO. | |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Paul H Gaver | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-16-84 | | 2b. HOUR
90 M | |
| 3. SEX
male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 27 26 | | 6. AGE (IN YEARS LAST BIRTHDAY)
58 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MI | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Claims Examiner | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Govt. | |
| 13a. STATE
MD | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Chevy Chase | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Ramond Gaver, Sr. | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Nina Speak | | 13e. STREET ADDRESS / ZIP CODE
8211 Ellingson Dr. 20815 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes. | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II 201-16-3283 | | 17. INFORMANT ADDRESS
Jeanne H. Gaver Same as item # 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Malignant Lymphoma</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>From Negative Septicemia</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 1/2 yrs
5 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 19 63</u> to <u>12-16</u> 19 <u>84</u> , that (I) (we) lost <u>saw</u> the deceased alive on <u>12-16</u> 19 <u>84</u> , and that in my (our) opinion death occurred on the date and hour and from the cause stated above. (I) (we) (did) (did not) <u>view</u> the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Bernard Nestor</u> | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12-18-84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BERNARD H OSTRON | | 22e. ADDRESS
5225 Pooks Hill RD BETH, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
12/19/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland, MD | |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.
NAME ADDRESS
5130 WI Ave. NW Wash., DC 20016 | | | | | | | |

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DEC 24 1984
STATE DEPT. OF HEALTH AND MENTAL HYGIENE
BALTIMORE, MARYLAND



1941

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THOMAS RIVIN

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| FOR
1- STATE REGISTRAR | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 3 3 7 7 2
REG. NO. | |
|--|--|---|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST LENA | | MIDDLE | | LAST GERSTEIN | | 2b. DATE KNOWN OF DEATH
ESTIMATED | | | | 2b. HOUR | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
3-21-1895 | | 6. AGE (IN YEARS)
LAST BIRTHDAY
89 YRS. | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
Dec 29 1984 | | 2d. HOUR
P M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Poland | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED
WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
St. Spg. | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hosp | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | | |
| 13a. STATE
MD | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
St Spg | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
#203 11434 Lockwood Dr | | | | 20904 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | Unavailable | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | Unavailable | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
102-05-1609 | | 17. INFORMANT
ADDRESS
Frances Spielberg, Same as 13 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sudden Myocardial Dis.
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | |
| None | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
John S. Rogers | | TITLE (SPECIFY)
M.D. Dep | | | | | | | | MEDICAL EXAMINER
DATE SIGNED
Dec 30, 1984 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
John S. Rogers | | ADDRESS
1919 Seminary Road
Silver Spring, MD 20910 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1/1/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Sinai Cemetery | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Miami, Dade County, Florida | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Sinai Funeral Home | | 25a. DATE REC'D. BY REGISTRAR
JAN 3 1985 | | | | 25b. REGISTRAR'S SIGNATURE
John S. Rogers | | | | | | | |
| 100 South Dixie Highway, Hallandale, FL 33009 | | | | | | | | | | | | | |

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

100 South Dixie Highway, Hollywood, FL 33009

Great Memorial Home

Burial

W. H. H. Cemetery

Miami, Dade County, Florida

John S. Powers

1919 Cemetery Road
Silver Spring, MD 20910

no

102-05-1609

Frances Seibert, June 12

June 12

Unavailable

Unavailable

Poland

United States

2-21-1897 80

Housesville

1202

Can Home

20204

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

cleared by Dr. Tauter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

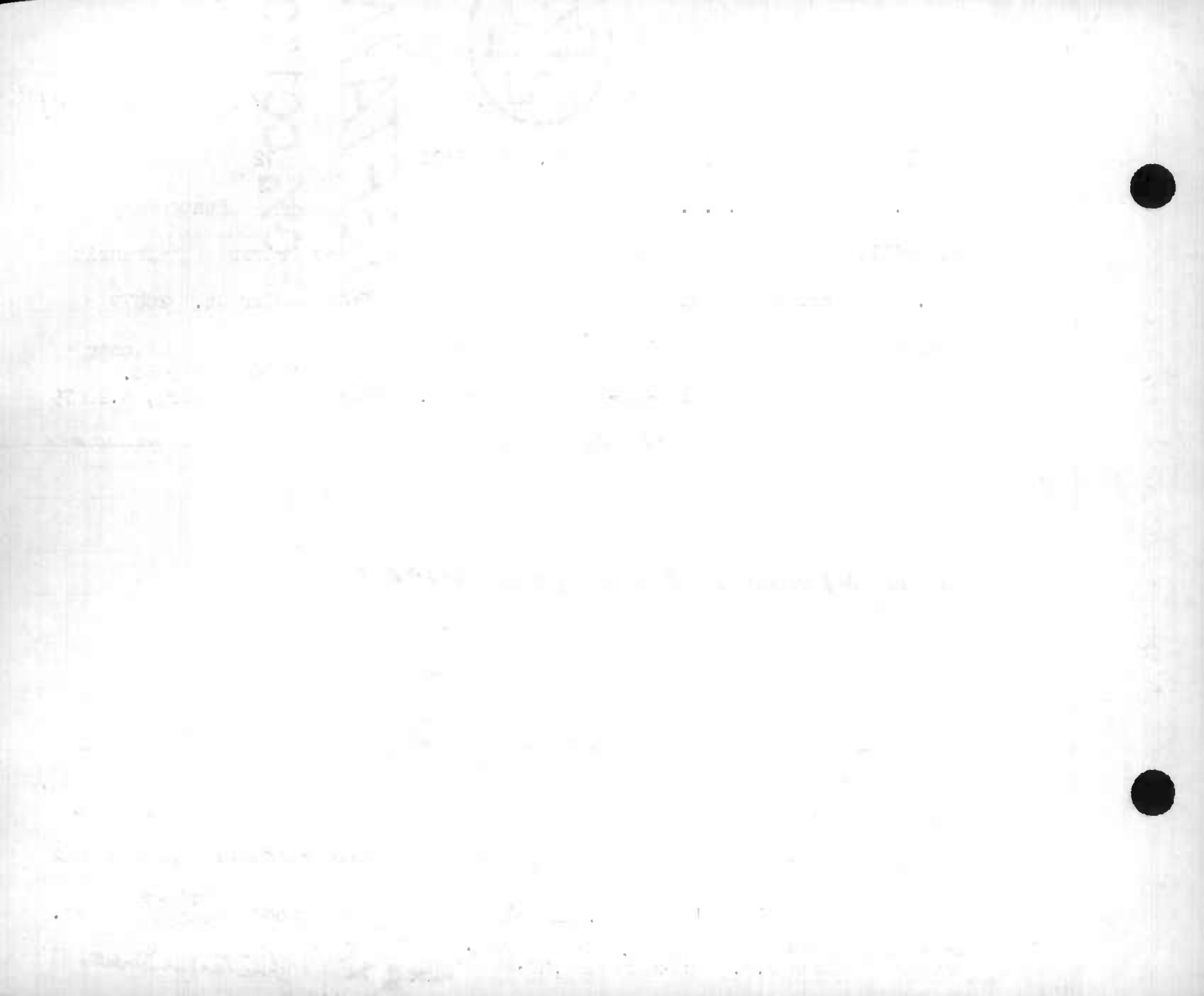
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

33973
REG. NO.

| | | | | | |
|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Neil Robert Gilbert | | MONTH DAY YEAR
12 4 84 | | 12 47 ^P | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan. 6 1912 | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pa. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH
Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Bus Driver | 12b. KIND OF BUSINESS OR INDUSTRY
Transit | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Gaithersburg | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Edward - Gilbert | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Laura Jane Skinner | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
194-03-5485 | 17. INFORMANT (Son)
Thomas W. Gilbert | | |
| | | ADDRESS
9670 Kanfer Ct. | | 17b. STREET ADDRESS / ZIP CODE
9672 Kanfer Ct. 20879 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>IMMEDIATE</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
<u>SEVERE DEGENERATIVE NEUROLOGICAL DISEASE</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from <u>Dec. 4, 1984</u> , to _____, 19____, that (we) last saw the deceased alive on <u>December 4, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>James A. Rossi</u> | | DEGREE
<u>MD</u> | | 22c. DATE SIGNED
<u>12-4-84</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>JAMES A. ROSSI MD</u> | | 22e. ADDRESS
<u>6111 EXECUTIVE BLVD., ROCKVILLE MD 20852</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | 23b. DATE
<u>12/6/84</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Ft. Lincoln</u> | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Brentwood Prince George Md.</u> | | |
| 24. FUNERAL DIRECTOR
<u>Gartner Sandison F.H.</u> | | 316 E. Dianond Ave.
Gaithersburg, Md. 20877 | | 25a. DATE REC'D. BY REGISTRAR
<u>DEC 11 1984</u> | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>John Tauter</u> | |

BP

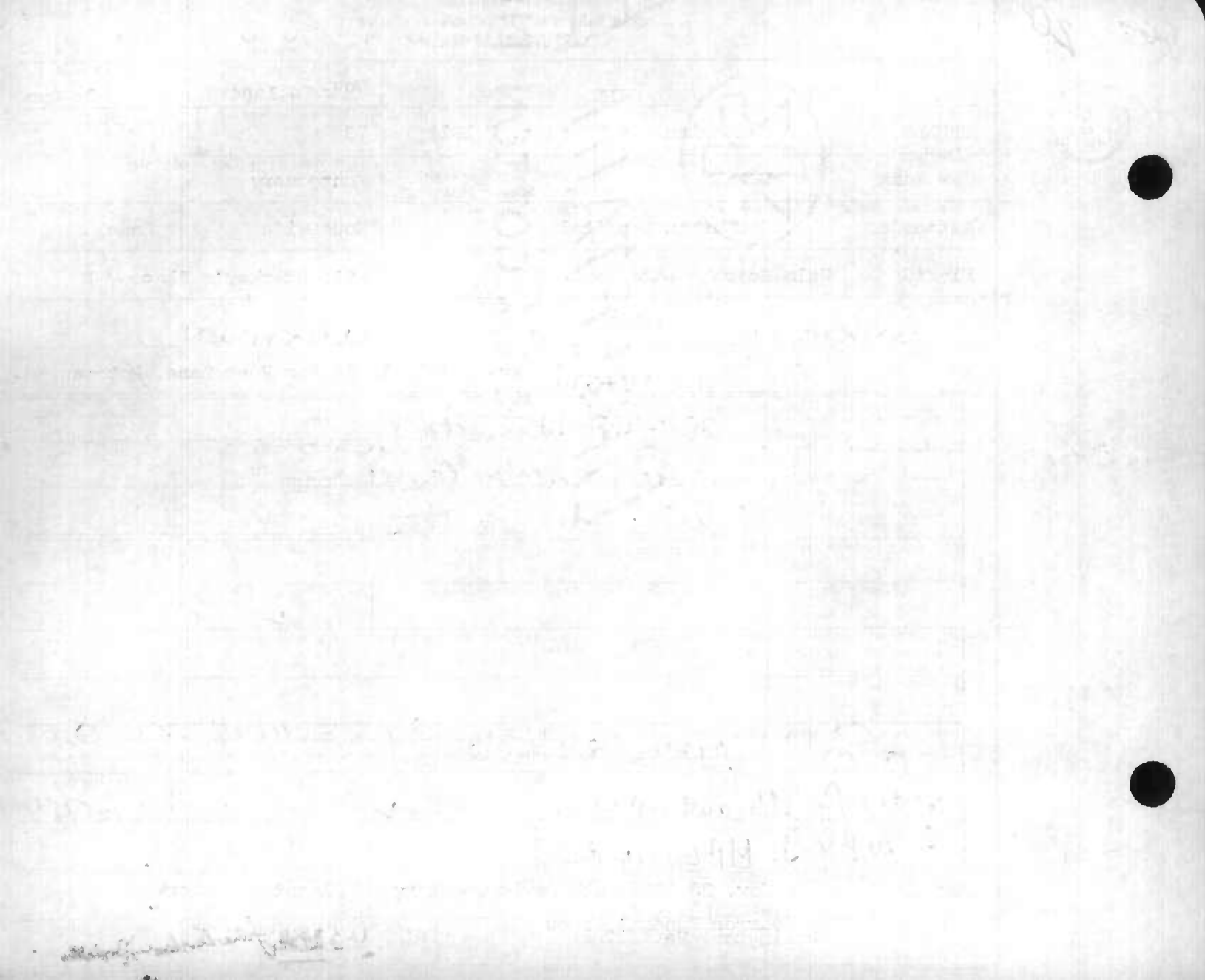


| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 33974
REG. NO. | |
|---|--|---|--|--|--|--|--|---|--|--------------------------------|--|
| 1 - FOR
STATE
REGISTRAR | | 1 DECEASED NAME
(TYPE OR PRINT) | | | | | | 2a DATE OF DEATH | | 2b HOUR | |
| IDA | | GILL | | | | | | Nov. 24, 1984 | | 3:00pm | |
| 3 SEX
FEMALE | | 4 RACE
Caucasian | | 5. DATE OF BIRTH
Sept. 7, 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN)
New York | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | | | | |
| 10 CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
Suburban Hospital | | | | 12a USUAL OCCUPATION
(TYPE OF WORK OR FORM OF WORKING LIFE)
Housewife | | 12b KIND OF BUSINESS OR
INDUSTRY
Home | | | |
| 13a STATE
Florida | | 13b COUNTY
Palm Beach | | 13c CITY OR TOWN
Lake Worth | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS
6730 Starkey's Place | | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
UNKNOWN Tackel | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNKNOWN | | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
NO NO OR UNKNOWN (IF N/A WAR OR DATES) | | | | | |
| 16b SOCIAL SECURITY NO.
N/A | | 17 INFORMANT
Fred Gill, 10816 Fox Hunt Lane, Potomac, Md. | | | | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intestinal obstruction</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic colon cancer</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>ulcerative colitis</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a I certify that (1) (this hospital) attended the deceased from <u>11/24/84</u> to <u>11/24/84</u> , that (1) (we) last saw the deceased alive on <u>11/24/84</u> and that in my (our) opinion death occurred on the date and hour and I am the causes stated | | | | | | | | | | | |
| 22b SIGNATURE
Sydney J. Malawer, M.D. | | DEGREE | | 22c DATE SIGNED
11/25/84 | | | | | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
SIDNEY J. MALAWER | | 22e ADDRESS
Rockville, Md. | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL
Burial | | 23b DATE
Nov. 28, 1984 | | 23c NAME OF CEMETERY OR CREMATORY
Beth David Cemetery | | | | 23d LOCATION
Elmont, New York STATE | | | |
| 24 FUNERAL DIRECTOR
NAME
Ives-Pearson Funeral Homes
Arlington, Va. 22201 | | 25 DATE RECEIVED BY REGISTRAR REGISTRAR'S SIGNATURE
DEC 4 1984 [Signature] | | | | | | | | | |

VO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


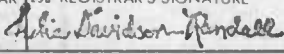
IMPORTANT: If item 21 is marked on item 18 above any injury, or other traumatic event, the medical examiner must be notified before burial or cremation.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1 AND 2 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|------------------------|--|--|--|---|--|---|-------------------------|---|--|--|--|---|--|---|--|---|--|--|--|--|--|
| <div>FOR REGISTRAR</div> <div>1- STATE REGISTRAR</div> | | | | | | | | | | | | | | | | | | | | | | | |
| 1 DECEASED NAME
(TYPE OR PRINT) | | | | | | FIRST
LOUISE | | | MIDDLE
GILLET | | | LAST
GILLET | | | | | | | | | | | |
| 2a DATE KNOWN OF DEATH | | MONTH
12 | | DAY
19 | | YEAR
84 | | 2b HOUR
2:27 | | 2c DATE PRONOUNCED DEAD | | MONTH
12 | | DAY
19 | | YEAR
84 | | 2d HOUR
2:27 | | | | | |
| 3 SEX
Female | | 4 RACE
White | | 5 DATE OF BIRTH
MONTH
Dec. 14, DAY
1902 YEAR
82 | | 6 AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | | IF UNDER 1 YR.
MONTHS
0 DAYS
0 HOURS
0 MIN | | IF UNDER 24 HRS.
HOURS
0 MIN
0 | | 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Dakota | | 7b CITIZEN OF WHAT COUNTRY?
United States | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | | |
| 10 CITY OR TOWN OF DEATH
Bethesda | | | | 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
7560 Springlake Drive, #A | | | | | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | | | 12b KIND OF BUSINESS OR INDUSTRY
Home | | | | | | | |
| 13a STATE
Maryland | | | | 13b COUNTY
Montgomery | | | | 13c CITY OR TOWN
Bethesda | | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e STREET ADDRESS
7560 Springlake Drive, #A | | | | | | | |
| 14 FATHER'S NAME
FIRST
Joseph MIDDLE
Lewis LAST
Page | | | | | | 15 MOTHER'S MAIDEN NAME
FIRST
Anna MIDDLE
Heidenreich LAST
Heidenreich | | | | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
No | | | | | | 16b SOCIAL SECURITY NO.
220 28 5764 | | | | | |
| 17 INFORMANT
Son 11541 Sullnick Way | | | | | | 17 ADDRESS
Thomas Page Gillett Gaithersburg Md | | | | | | | | | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic carcinoma
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
carcinoma of the lung.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
None | | | | | | | | | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION
None | | | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED?
None | | | | | | 20 AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
None | | | | | | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | 21f LOCATION
STREET
CITY OR TOWN
COUNTY
STATE | | | | | | | | | | | |
| 22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
 | | | | | | TITLE (SPECIFY)
Deputy M.D. | | | | | | MEDICAL EXAMINER
1919 Seminary Road | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
John S. Rogers, M.D. | | | | | | ADDRESS
Silver Spring, Montgomery, Md. | | | | | | DATE SIGNED
12/19/84 | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | | | | 23b DATE
Dec. 19, 1984 | | | | | | 23c NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory Alexandria, Virginia | | | | | | | | | | | |
| 24 FUNERAL DIRECTOR
NAME
ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND | | | | | | 25a DATE REC'D. BY REGISTRAR
DEC 24 1984 | | | | | | 25b REGISTRAR'S SIGNATURE
 | | | | | | | | | | | |

John S. Rogers, M.D.

Silver Spring, Montgomery, Md.
1219 Seminary Road
Deputy

12/19/84

_____ X

_____ X

None

None

None

carcinoma of the lung.

Metastatic carcinoma

Maryland Montgomery Bethesda 7560 Springlake Drive, WA

Bethesda 7560 Springlake Drive, WA

Montgomery County

X

Female White Dec. 14, 1902 82

12/19

84 A.

CIMMITE

LOUISA

12/19

84 A.

X

5:27
5:27
5:27

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH33970
REG. NO.1- FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Marie Gaedeke | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 28 84 | | | 2b. HOUR
9:08 PM | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 5 23 | | 6. AGE (IN YEARS LAST BIRTHDAY)
61 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hosp. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY
C.P.A. | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
11807 Pittson Road 20906 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Elmer William Smith | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Barbara Sebald | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
215-18-2862 | | 17. INFORMANT
ADDRESS
Ms. Anna L. Smith - Same as #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Multiple Myocardial Infarcts
DUE TO, OR AS A CONSEQUENCE OF (c) Severe Coronary Heart Disease | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Minutes
1 1/2 years
Years | | |
| | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes Mellitus | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) this hospital attended the deceased from 11/11/84 to 12/28/84, that (I) (we) lost saw the deceased alive on 12/25/84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Herman B. Segal M.D. | | | DEGREE
M.D. | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/29/84 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Herman B. Segal | | | 22e. ADDRESS
10313 Georgia Ave
Silver Spring Maryland | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | | 23b. DATE
12/31/84 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR
NAME
Anatomy Board | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 4 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Rendall | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 is not as any injury, or other traumatic event, the medical examiner must be contacted once.

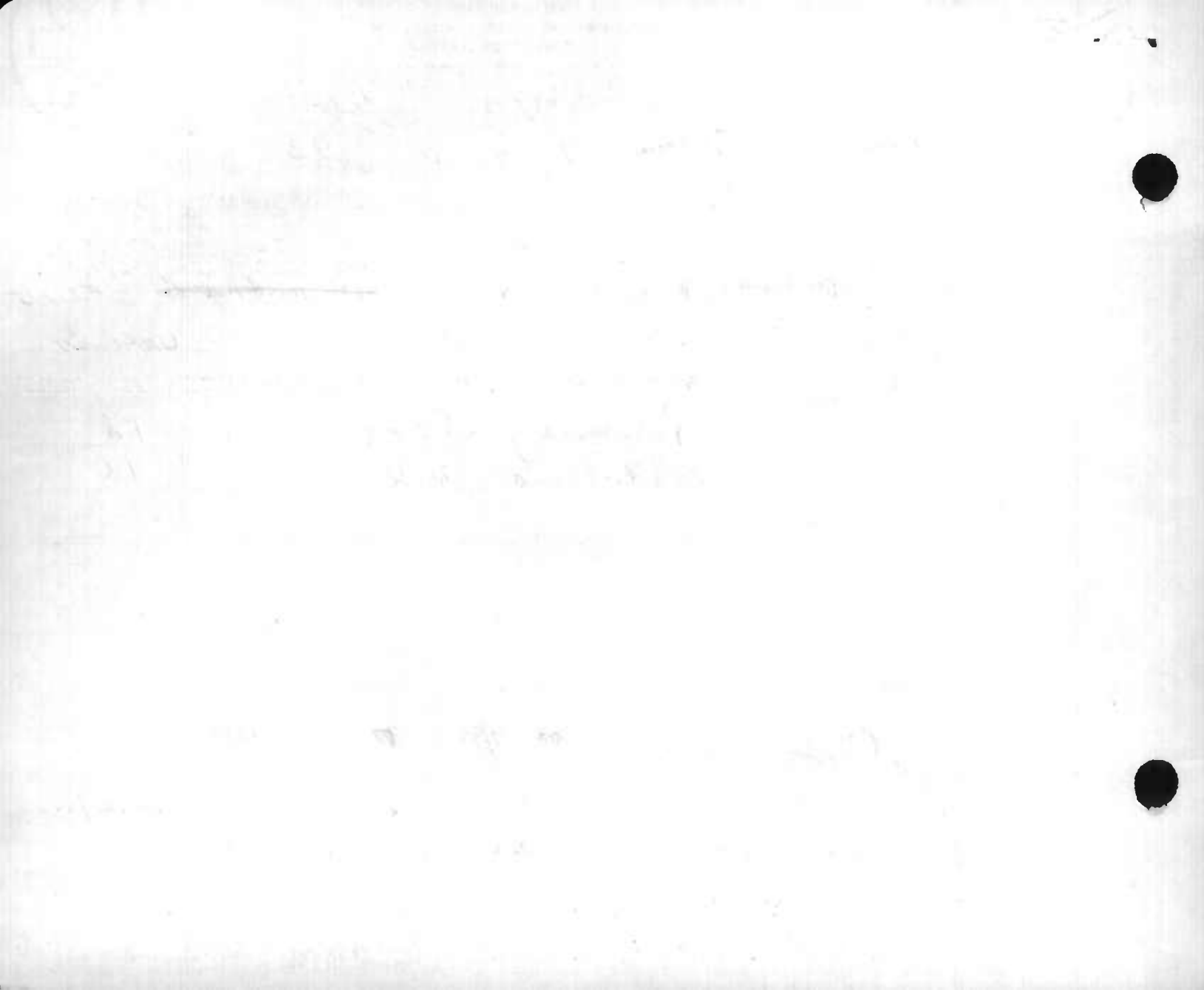


| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 33977 | |
|---|--|--|--|--|--|---|--|--|--|--|--|
| 1- STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Belle | | Goldberg | | | | | | 12/21/84 | | 3:20 P.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| FEMALE | | CAUCASIAN | | 7. MONTH DAY YEAR | | 93 YRS | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| POLAND | | USA | | | | Montgomery County, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Bethesda | | Suburban Hospital | | HOUSEWIFE | | HOME MAKER | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS, ZIP CODE | | | |
| md | | Montgomery | | Rockville | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 6614 VINCENT LANE BALTO, MD. | | #2125 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| HENRY | | KATE | | NO | | 578-34-4613 | | MR. JACOB STEINER | | 6614 VINCENT LANE (21215) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Pulmonary edema | | | | | | | | | | 1d | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Cardiogenic shock | | | | | | | | | | 1e | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | 21d. INJURY OCCURRED | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | 21g. CITY OR TOWN | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET | | COUNTY | | | | | |
| AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | STATE | | | | | |
| 22a. I certify that (I, this hospital) attended the deceased from 12/21/84 to 12/21/84, that (I, we) last saw the deceased alive on 12/21/84, and that (my, our) opinion of death occurred on the date and hour and from the causes stated above. (I, we) (did, did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | |
| Peter Sherer | | | | MD | | | | 12/22/84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| Peter Sherer MD | | | | 3947 Ferrara Dr. Wheaton md | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | |
| BURIAL | | 12/23/84 | | BALTIMORE HEBREW CEM | | BALTIMORE, MD. | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215) | | | | | | DEC 28 1984 | | John Davidson-Randall | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

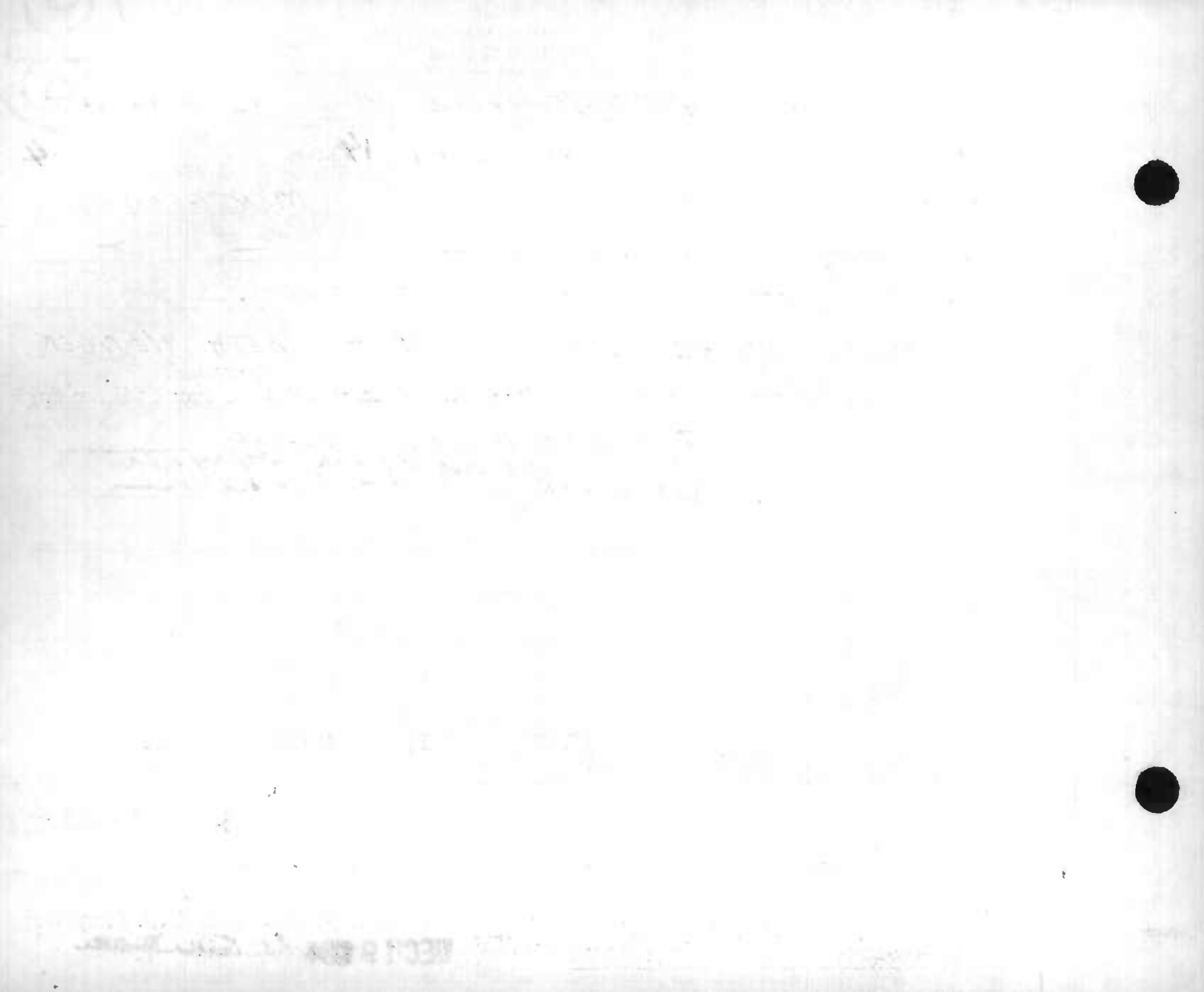
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| | | | | | |
|--|--|---|---|--|---|
| Item 13 per phone 12/31/84 dad | | STATE OF MARYLAND | | 33978 | |
| FOR
1- STATE
REGISTRAR | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ADAM MATTHEW Goldkind | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 16 84 | | 2b. HOUR
1455 P |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
12 16 84 | | 6. AGE (IN YEARS LAST BIRTHDAY)
15 min YRS. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA. - | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MDA cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
- | | 12b. KIND OF BUSINESS OR INDUSTRY
- |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | 13b. CITY OR TOWN
Montgomery | 13c. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input type="checkbox"/> NO | 13d. STREET ADDRESS / ZIP CODE
5 Balboa Ct. - 20907 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JERRY HOWARD GOLDKIND | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
DEBRA BETH WEINGER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
n/a | 17. INFORMANT
ADDRESS
Maryland
Jerry H. Goldkind; 5 Balboa Court; Silver Spring | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Severe birth Asphyxia
DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/16 , 19 84 , to 12/16 , 19 84 , that (I) (we) last saw the deceased alive on 12/16 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Georgis G. Kefale | | DEGREE
MD | | 22c. DATE SIGNED
12/16/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Georgis G Kefalino | | 22e. ADDRESS
1500 Forest Glena Road | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/18/84 | 23c. NAME OF CEMETERY OR CREMATORY
B'Nai Israel Cong. Cemetery; Oxon Hill; P.G.; Maryland | | 23d. LOCATION
CITY OR TOWN COUNTY STATE |
| 24. FUNERAL DIRECTOR
NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS
ADDRESS 1170 Rockville Pike; Rockville, Maryland 20854 | | | | | |

BP

DEC 19 1984
Jula Davidson-Rodriguez



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

33979

F

FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|----------------------|--|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Esther | | FIRST | | MIDDLE | | LAST GOLFER | | 2b. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 29 1984 | | 2d. HOUR 10¹⁰ AM | |
| 3. SEX F | 4. RACE White | 5. DATE OF BIRTH
MONTH DAY YEAR 5 19 23 | | 6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD 12 29 1984 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Lithuania | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Co-Owner | | 12b. KIND OF BUSINESS OR INDUSTRY Restaurant | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Sil. Spg. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2700 Loma Street 20902 | | | |
| 14. FATHER'S NAME
FIRST Yehuda MIDDLE Gordon LAST Gordon | | | | 15. MOTHER'S MAIDEN NAME
FIRST Miriam MIDDLE Goldberg LAST Goldberg | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 577-40-0086 | | 17. INFORMANT Silver Spring, Md. Edward Golfer; 2700 Loma Street | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST.
DUE TO, OR AS A CONSEQUENCE OF
(b) PNEUMONIA, METASTATIC DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) METASTATIC BREAST CARCINOMA.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
SEPSIS & LOW WHITE BLOOD COUNT. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE [Signature] | | | | TITLE (SPECIFY) _____ | | | | DATE SIGNED 12/29/84 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) _____ | | | | ADDRESS _____ | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 12-30-1984 | | 23c. NAME OF CEMETERY OR CREMATORY Judean Mem. Gardens | | 23d. LOCATION
CITY OR TOWN COUNTY STATE Olney, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME DANZANSKY GOLDBERG | | | | ADDRESS 1170 Rockville Pike | | | | 25a. DATE REC'D. BY REGISTRAR JAN 4 1985 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

RELEASED BY MEDICAL EXAMINER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with you after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 33980 | | REG. NO. | | | | | |
| I. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| GABRIEL GOROMBAY | | GABRIEL J. GOROMBAY | | 12 18 84 | | 12:24 PM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | |
| male | | Caucasian | | 10 16 36 | | 58 | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Ill. | | USA | | | | MONTGOMERY | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| BETHESDA | | SUBURBAN HOSPITAL | | Retired Translator | | World Bank | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| MARYLAND | | MONTGOMERY | | CHERRYCHASE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 3405 West Coquetin Terr. | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| George | | Julia | | yes | | 721-10-0293-A | | Mrs. Renee H. Gorombey item 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Massive intracerebral hemorrhage</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic renal disease and transplant</u>
Tuberculous | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | |
| | | HOUR A.M. MONTH DAY YEAR | | | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 12/18/84 | |
| | | P.M. | | | | | | 12/18/84 | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>10:30 AM</u> to <u>12:24 PM</u> , that (I) (we) last saw the deceased alive on <u>12/18/84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If signed by the medical examiner, the signature must be in ink.) | | 22b. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22c. ADDRESS | | 22d. DATE SIGNED | | | |
| | | John Thomas Lord | | 5632 Shields Dr. Bethesda MD | | 12/18/84 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | 23e. CITY OR TOWN | |
| Cremation | | 12-20-84 | | Cedar Hill Crematory | | Suitland, | | MD. | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | 25c. CITY OR TOWN | | 25d. STATE | |
| Jos. Gawler's Sons, Inc. | | DEC 26 1984 | | Julia Davidson | | | | | |
| 5130 Wisc. Av NW Wash. DC 20016 | | | | | | | | | |

25

2105

f

I wish you were here. - 1976-1977

15089

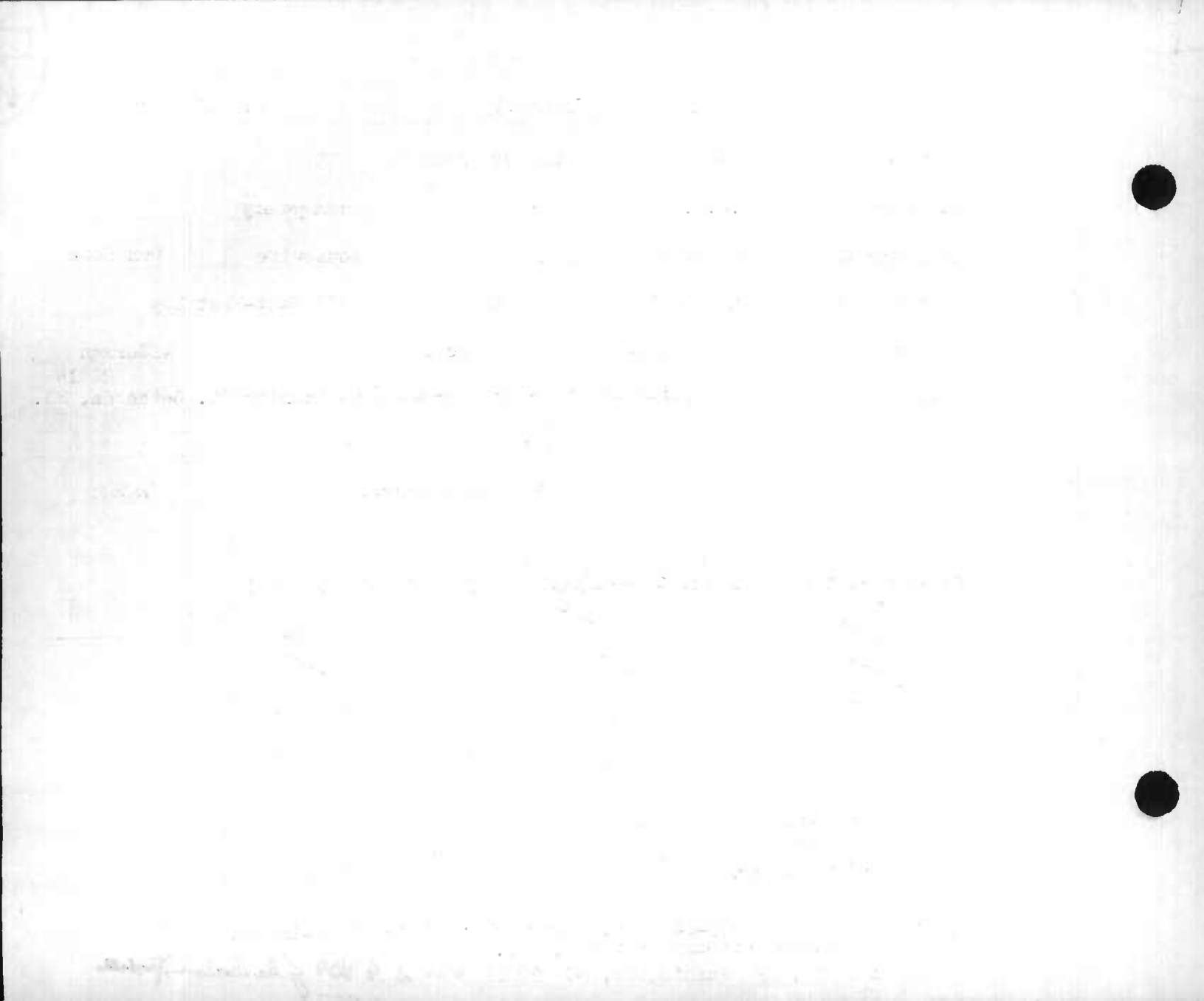
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH 8 4 | | | | | | | | | | 33981
REG. NO. | |
|--|--|---|--|---|--|---|--|---|--|---|--|
| 1. FOR
STATE
REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
FRIEDA R. GOSDSIK | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 17 84 | | | | 2b. HOUR
4:12 P M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 23 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Tennessee | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
4521 East-West Hwy 20814 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Max Monson | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rose Alderman | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
044-18-1951 | | 17. INFORMANT
ADDRESS
Bonnie Brown 6003 Henning St. Bethesda, Md. | | | | 20814 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RENAL FAILURE | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 DAYS | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) HYPERTENSION | | | | | | | | | | YEARS | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
CHRONIC OBSTRUCTIVE LUNG DISEASE, ULCERATIVE COLITIS | | | | | | | | | | | |
| 19a. DATE OF OPERATION
/ | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
/ | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
/ | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
/ | | 21f. LOCATION
STREET
/ | | CITY OR TOWN
/ | | COUNTY
/ | | STATE
/ | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5 , 19 78 , to 12/17 , 19 84 , that (I) (we) lost
saw the deceased alive on 12/17 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) see the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
[Signature] MD | | | | DEGREE
MD | | | | 22c. DATE SIGNED
12/17/84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ARNOLD G. LEVY, M.D. | | | | 22e. ADDRESS
1106 SPRING ST.
SILVER SPRING, MD. 20910 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | 23b. DATE
12-17-84 | | 23c. NAME OF CEMETERY OR CREMATORY
Georgetown Med. School | | 23d. LOCATION
CITY OR TOWN
Washington | | COUNTY
DC | | STATE
DC | |
| 24. FUNERAL DIRECTOR
NAME
Columbia Mortuary Services, Inc.
ADDRESS
225 Missouri Ave. NW Washington, DC 20011 | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 24 1984 | | | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

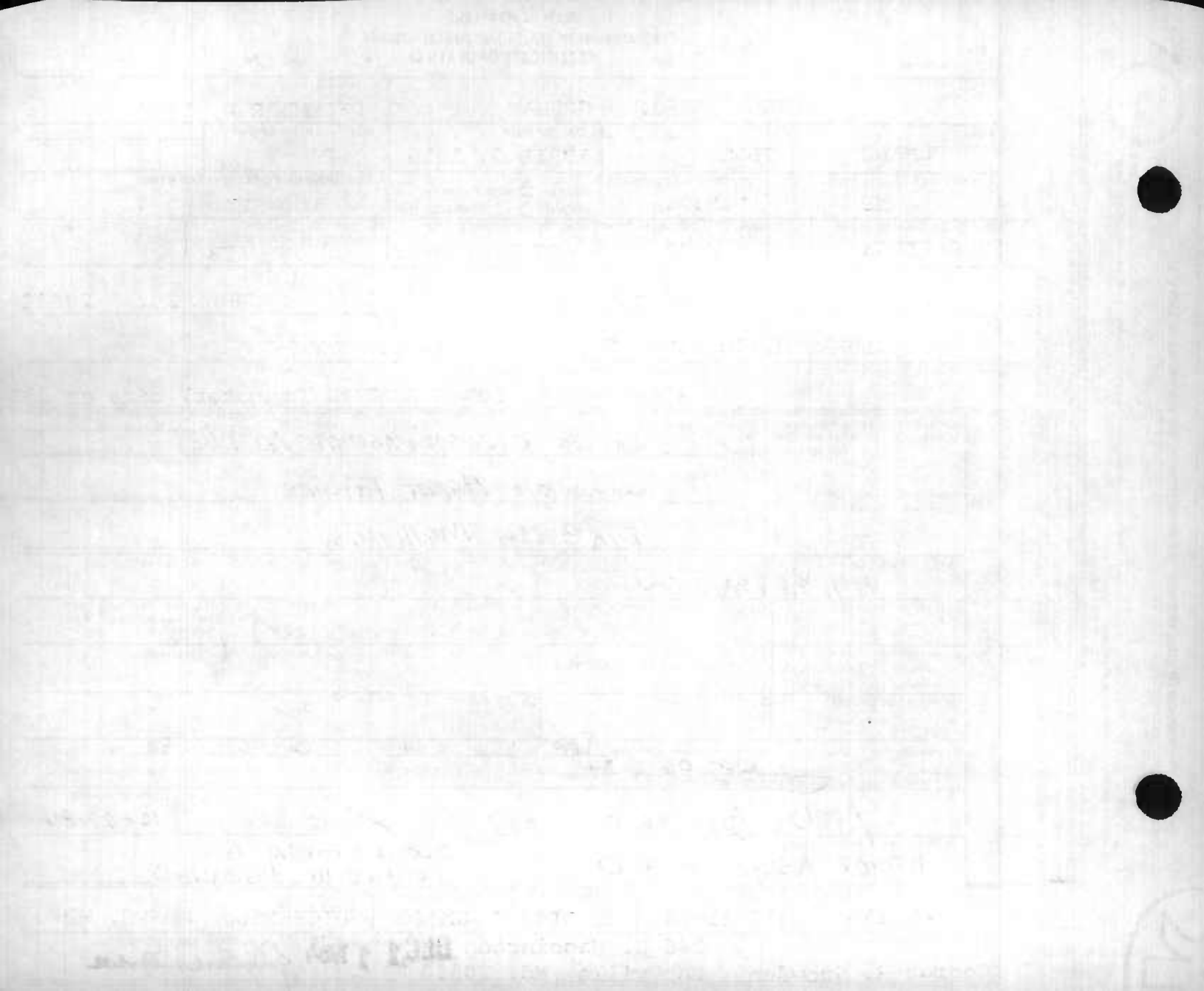
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 3 9 8 2
REG. NO.

| | | | | | | | | | | |
|--|--|---|---|---|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ETHEL MARIE GRAHAM | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 6, 1984 | | | 2b. HOUR
M
A | | | | |
| 3. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
APRIL 3, 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
ROCKVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SHADY GROVE ADVENTIST HOSP. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | | 13b. COUNTY
MONTG. | | 13c. CITY OR TOWN
DICKERSON | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
18620 TRUNDLE RD. 20842 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ELBERT M. JOHNSON, SR. | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ANNIE L. MCKEMMA | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | 16b. SOCIAL SECURITY NO.
214-34-6343 | | 17. INFORMANT
ADDRESS
DORIS GRAHAM (Daughter) same as #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MASSIVE CEREBROVASCULAR ACCIDENT
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) CONGESTIVE HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(c) DILATED MYOCARDIUM
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2. OTHER HYPERNTIC CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: HYPERTENSION | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 06 , 19 84 , to Dec 06 , 19 84 , that (I) (we) lost
saw the deceased alive on Dec 06 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Hector Asuncion, M.D. | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
12-07-84 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HECTOR ASUNCION, M.D. | | | 22e. ADDRESS
20010 FISHER AVE
POOLESVILLE, MARYLAND | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
12-11-84 | | 23c. NAME OF CEMETERY OR CREMATORY
MT ZION CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
DICKERSON, MONTG. MD | | | |
| 24. FUNERAL DIRECTOR
NAME
George R. Snowden | | | 24b. ADDRESS
246 N. Washington
Rockville, Md. 20850 | | DATE REC'D. BY REGISTRAR
DEC 11 1984 | | 25b. REGISTRAR'S SIGNATURE
Jeta Davidson-Rodriguez | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 3 9 8 3
REG. NO.1- FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
<u>Angel Francis Grafton</u> | | | 2a. DATE OF DEATH MONTH DAY YEAR
<u>12-23-84</u> | | | 2b. HOUR
<u>3:15 AM</u> | |
| 3. SEX
<u>Male</u> | | 4. RACE
<u>White</u> | | 5. DATE OF BIRTH MONTH DAY YEAR
<u>12-22-84</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MINS
<u>YRS.</u> <u>16</u> | |
| 7a. BIRTHPLACE (COUNTRY)
<u>MD</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Montgomery</u> MD. | |
| 10. CITY OR TOWN OF DEATH
<u>Silver Spring</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Holy Cross Hospital</u> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Never Employed</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>N/A</u> | |
| 13a. STATE
<u>va</u> | | 13b. CITY OR TOWN
<u>Fairfax</u> | | 13c. CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE
<u>6917 Duke Dr 22307 99999</u> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<u>Charles Grafton</u> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<u>Theodora Burch McCaffray</u> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| 17. INFORMANT (Mother)
<u>Theodora M. Grafton</u> | | ADDRESS
<u>6917 Duke Drive</u> | | CITY
<u>Alexandria</u> | | STATE
<u>VA</u> | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BYIMMEDIATE CAUSE (a) respiratory arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) anencephaly

DUE TO, OR AS A CONSEQUENCE OF

(c)

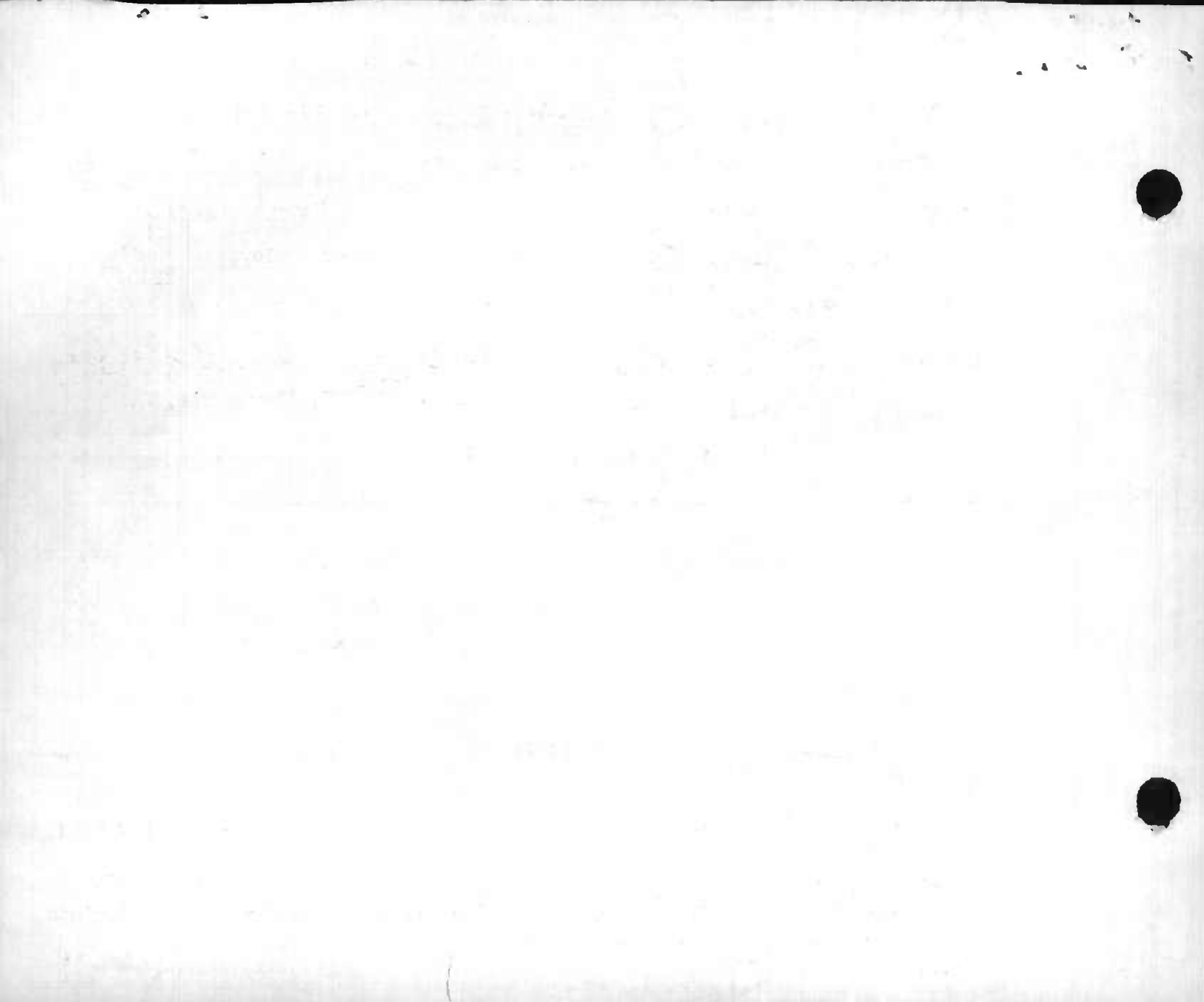
APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) <u>the hospital</u> attended the deceased from <u>12-22-84</u> , 19 <u>84</u> , to <u>12-23-84</u> , 19 <u>84</u> , that (I) <u>was</u> lost
saw the deceased alive on <u>12-23</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Jeffrey C. Green</u> | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>12-23-84</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Jeffrey C. Green</u> | | 22e. ADDRESS
<u>Holy Cross Hosp., Silver Spring, MD</u> | | | | | |

| | | | | | | | |
|---|--|-------------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Cremation</u> | | 23b. DATE
<u>January 2, 1984</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Metropolitan Crematory</u> | | 23d. LOCATION CITY OR TOWN COUNTY
<u>Alexandria Virginia</u> | |
| 24. FUNERAL DIRECTOR
NAME <u>Robert A. Pumphrey</u>
P.A. Bethesda, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR
<u>JAN 9 1985</u> | | 25b. REGISTRAR'S SIGNATURE
<u>John Davidson</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 33984 | | | |
|--|--|---|--|--|--|--|--|
| 1 - FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
FREDERIC S. GRAY | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 21, 1984 | | 2b. HOUR
6:15 AM | |
| 3 SEX
MALE | | 4 RACE
WHITE | | 5 DATE OF BIRTH
SEPTEMBER 18, 1944 | | 6 AGE (IN YEARS LAST BIRTHDAY)
40
YRS MONTHS DAYS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
OHIO | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10 CITY OR TOWN OF DEATH
GAITHERSBURG | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
18800 KEIFFER WAY | | 12a USUAL OCCUPATION
(TYPE OR NATURE OF WORKING LIFE)
ATTORNEY | | 12b. KIND OF BUSINESS OR INDUSTRY
LAW | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE COUNTY CITY OR TOWN
MARYLAND MONTGOMERY GAITHERSBURG | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
18800 KEIFFER WAY 20879 | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
RICHARD S. GRAY | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE
RUTH WENGER | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b SOCIAL SECURITY NO.
296-38-4025 | | 17 INFORMANT ADDRESS
MARY LOU GRAY, WIFE, SAME AS ITEM #13 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Astrocytoma
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1976 | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (1) the hospital attended the deceased from 11/20 , 19 75 , to 12/21 , 19 84 , that (we) last saw the deceased alive on Oct , 19 84 , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (b) (we/they) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Patricia Kellogg | | DEGREE
John Saia M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/21/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Patricia Kellogg | | 22e. ADDRESS
John Saia 89 Viers Mill Rd Rockville, MD 20851 | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
CREMATION | | 23b DATE
12/21/84 | | 23c NAME OF CEMETERY OR CREMATORY
METROPOLITAN CREMATORY | | 23d LOCATION
CITY OR TOWN COUNTY
ALEXANDRIA VIRGINIA | |
| 24 FUNERAL DIRECTOR
NAME
RICHARD RAPP, INC.
ADDRESS
1804 T ST., N.W., WASH., D.C. 20009 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 26 1984 | | | |
| | | | | 25b REGISTRAR'S SIGNATURE
Julia Davidson Rando | | | |

OPERATION 12/21/84 METROPOLITAN CREATORY ALEXANDRIA VIRGINIA

NO

506-28-1032

MARY LOU GRAY, WIFE, SAME AS ITEM #13

RICHARD

2.

GRAY

RUTH

WINGER

MARYLAND

NEWGENTRY

CATHERSBURG

X

18800 KEEPER WAY

30829

CATHERSBURG

18800 KEEPER WAY

ATTORNEY

MAN

CHILD

U.S.A.

X

NEWGENTRY

WIFE

WIFE

SEPTEMBER 18, 1944 TO

GRAY

2.

PHOTOCOPY

DECEMBER 21, 1984

6:15 AM

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 33985

| | | | | | |
|---|--|--|---|---|--------------------------|
| 1. FOR
STATE
REGISTRAR | | 2a. DATE KNOWN
OF ESTI-
DEATH MATED | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | 2c. DATE
PRONOUNCED
DEAD | | 2d. HOUR | |
| RUBY | | 12 1 19 84 | | M | |
| Simpson GRAY | | 12 22 19 84 | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR. | 7. IF UNDER 24 HRS. |
| Fe | CAUC | Feb. 3, 1895 | 89 YRS. | MONTHS | DAYS |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED | NEVER MARRIED | WIDOWED | DIVORCED |
| Norfolk, Va. | USA | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS
OR INDUSTRY | |
| CHEVY CHASE | 5500 FRIENDSHIP BLVD | Clerk-Typist Ret. | | US GOV'T. | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| MD | MONTGOMERY | CHEVY CHASE | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 5500 FRIENDSHIP BLVD | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | |
| James Edward Simpson | Rebecca Mason Simpson | None (None) | | | |
| 16b. SOCIAL SECURITY NO. | 17. INFORMANT | | | | |
| 578-09-9183 | Patricia M. Wyatt, 25 Makalapa Dr., Honolulu, Hawaii 96815 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | |
| (b) CORONARY ARTERIOSCLEROSIS | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | |
| 20. AUTOPSY? | | | | | |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | HOUR A.M. MONTH DAY YEAR | | FOUND ON FLOOR | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | |
| WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | HOME | | CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | |
| ACTUAL SIGNATURE | | | | | |
| TITLE (SPECIFY) | | | | | |
| M.D. DEPT MEDICAL EXAMINER | | | | | |
| DATE SIGNED 12/22/84 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | | |
| ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | |
| 23b. DATE | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | | | |
| 23d. LOCATION | | | | | |
| CITY OR TOWN COUNTY STATE | | | | | |
| 24. FUNERAL DIRECTOR | | | | | |
| NAME ADDRESS | | | | | |
| 25a. DATE REC'D. BY REGISTRAR | | | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

Removal Dec. 26, 1984 Chambers Funeral Home Riverdale, P.G. Cty., Maryland
W.W. CHAMBERS CO. 8655 Georgia Ave., S/S. Md. 20910
DEC 27 1984

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

Handwritten notes and stamps, including a large circular stamp in the center. The text is mostly illegible due to blurriness and bleed-through from the reverse side of the page.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 33986

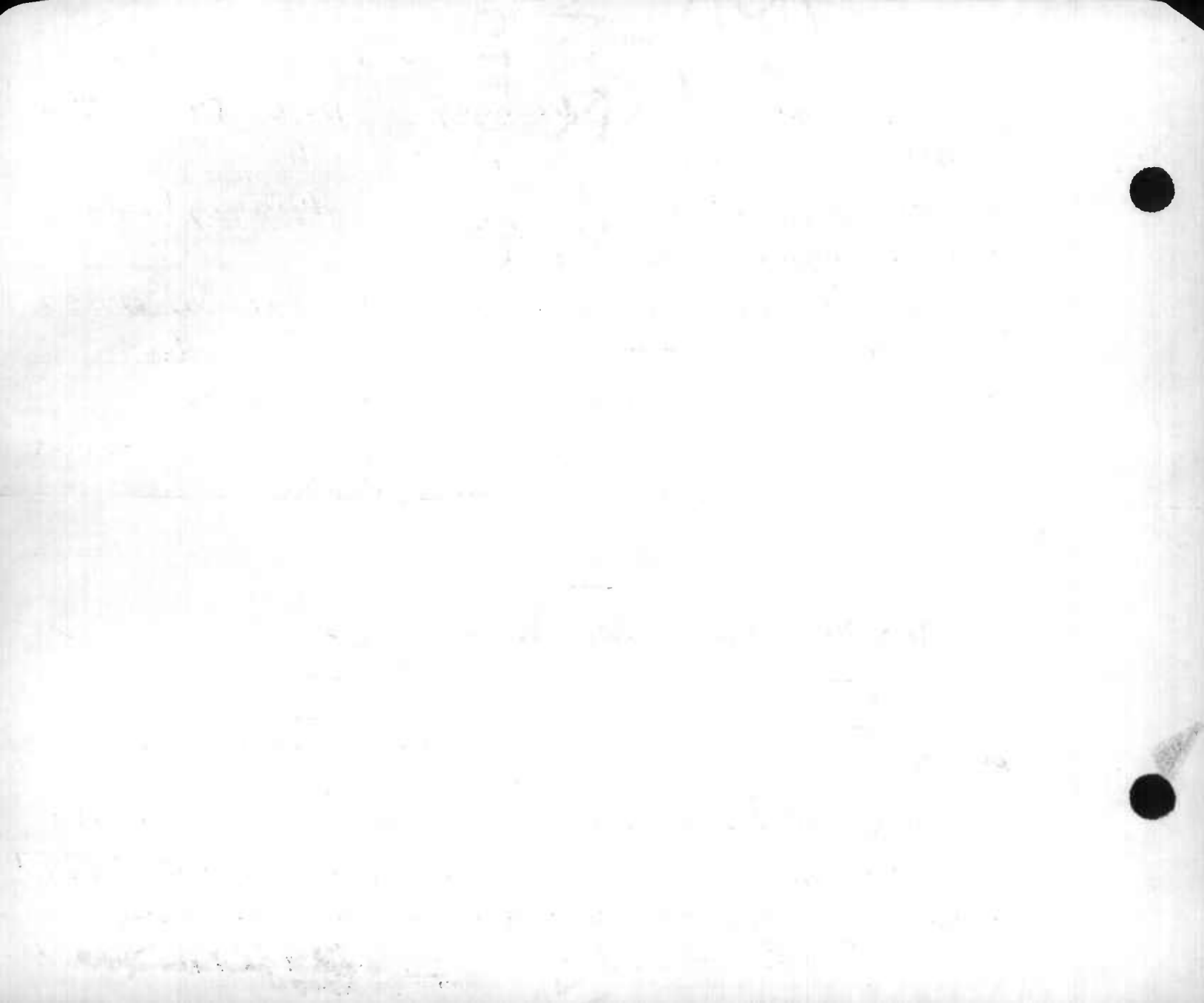
| | | | | | | | |
|--|--|---|---|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Leon Greenberg | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-6-84 | | | 2b. HOUR
7:15 A.M. | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
7-1-13 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Takoma Park Md | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Hospital | | | | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE
M.D. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
10500 Rockville 20852 | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Morris J. Greenberg | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Shayna Katz | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II | | 17. INFORMANT
ADDRESS
Rena Greenberg same as #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Primary Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
48 hours |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | |
| 19a. DATE OF OPERATION
12-5-84 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Coronary Artery Disease | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-5-1984 to 12-6-1984 , that (I) (we) lost
saw the deceased alive on 12-6-1984 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Paul Darlingston Kierulff, M.D. | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12-6-84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Paul Darlingston Kierulff, M.D. | | | | 22e. ADDRESS
831 University Boulevard East St. Paul, Virginia | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec. 9, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
King David Mem. Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Falls Church, Virginia | |
| 24. FUNERAL DIRECTOR
NAME
Ives-Pearson Funeral Homes | | | | 25a. DATE REC'D. BY REGISTRAR
REGISTRAR'S SIGNATURE
John D. ... | | | |
| ADDRESS
Falls Church, Va. 22046 | | | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before any removal of the body.



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 33981 | |
|--|-------------------------|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Rhoda C. GREENBLATT | | 2a. DATE OF DEATH
DECEMBER 11, 1984 | | 2b. HOUR
4:54 M | |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MARCH 3, 1925 | | 6. AGE (IN YEARS LAST BIRTHDAY)
59 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
HOLY CROSS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK OR WORKING LIFE)
SALES LADY | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
HOLY CROSS HOSPITAL | | 12b. KIND OF BUSINESS OR INDUSTRY
DRUG STORE | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
MARYLAND | | 13b. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c. STREET ADDRESS / ZIP CODE
1100 OWENS ROAD, APT. 716 20745 | |
| 14. FATHER'S NAME
MEYER | | 15. MOTHER'S MAIDEN NAME
LENA LIPSCHITZ | | 16. SOCIAL SECURITY NO.
070-18-9695 | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?
NO | | 17b. SOCIAL SECURITY NO.
070-18-9695 | | 17c. INFORMANT
ALAN I. GREENBLATT, 1729 FILLMORE COURT CROFTON, MARYLAND | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) Cerebral Hemorrhage
DUE TO, OR AS A CONSEQUENCE OF
(c) Cerebrovascular accident | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 week | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Asthma | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/25 , 19 84 , to 12/11 , 19 84 , that (I) (we) last saw the deceased alive on 12/11 , 19 84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death. | | | | | |
| 22b. SIGNATURE
Alan Weinstein | | DEGREE | | 22c. DATE SIGNED
12/16/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Alan Weinstein MD | | 22e. ADDRESS
10313 Georgia Ave Silver Spring MD | | 22f. DATE REC'D. BY REGISTRAR | |
| 23a. BURIAL, CREMATION, REMOVAL
CREMATION | | 23b. DATE
12/12/1984 | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL CREMATORY | |
| 23d. LOCATION
SUITLAND, PR. GEORGE'S, MD. | | 23e. DATE REC'D. BY REGISTRAR | | 23f. REGISTRAR'S SIGNATURE
John Davidson | |
| 24. FUNERAL HOME
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C. 20001 | | | | | |

BP

100
90
80
70
60
50
40
30
20
10
0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Paper may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) SUSAN PALMER GREENWELL | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 25, 1984 | | | 2b. HOUR
M | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 2, 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
84 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | | | |
| 10. CITY OR TOWN OF DEATH
Chevy Chase | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
At home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Md. | | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Chevy Chase | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Dr. Robert D. Palmer | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Dee Burch | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT
ADDRESS
Sarah Politano Same as 13e. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE PULMONARY EDEMA
DUE TO, OR AS A CONSEQUENCE OF (c) CONGESTIVE HEART FAILURE | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
10 MINUTES
6 HOURS
2 MONTHS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
REFRACTORY ANEMIA | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JULY 19 84 , to DEC. 25 19 84 , that (I) (we) lost saw the deceased alive on DEC. 25 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Joseph D. Connor, M.D. | | | | | DEGREE
M.D. | | 22c. DATE SIGNED
DEC. 25, 1984 | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOSEPH D. CONNOR, M.D. | | | | | 22e. ADDRESS
BETHESDA, MD 20814
9420 OLD GEORGETOWN ROAD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
12/29/84 | | 23c. NAME OF CEMETERY OR CREMATORY
All Saints Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Oakley St. Mary's Md. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
W. Clarke Mattingley Leonardtown, Md. | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 31 1984 | | 25b. REGISTRAR'S SIGNATURE
Judith Davidson-Randall | | | |



RESPIRATORY ARREST
 ACUTE PULMONARY EDEMA
 CONGESTIVE HEART FAILURE
 ANEMIA

DEC 22 1954
 DEC 17 1954

THOMAS D. CUMMINS, M.D.
 1000 W. 10th St.
 ST. LOUIS, MO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 REC 3 9 8 9

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|--|-----------------------|---|---|---|-------------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Andrew Grossman | | | | | | 2a. DATE KNOWN OF DEATH
EST. MATED Dec 31, 1984 | |
| 3. SEX
E W | 4. RACE
E W | 5. DATE OF BIRTH
MONTH DAY YEAR June 16 1927 | 6. AGE (IN YEARS)
LAST BIRTHDAY YRS. 27 | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | IF UNDER 24 HRS.
HOURS MIN | 2c. DATE PRONOUNCED DEAD
Dec 31, 1984 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Gaithersburg | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
961 Kloppe Rd Apt 78 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)
Registered Nurse | |
| 12b. KIND OF BUSINESS OR INDUSTRY
Hospital | | 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY Montgomery 13c. CITY OR TOWN Gaithersburg | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Harold Siegel | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Thelma Altschuler | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) No (IF YES, GIVE WAR OR DATES) None | | | |
| 16b. SOCIAL SECURITY NO.
115-44-1162 | | 17. INFORMANT
ADDRESS 961 Clopper Rd. T-1
Martin Grossman, Husband, Gaithersburg, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Carcinoma
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last }
(b) Small Cell Carcinoma of Lung
DUE TO, OR AS A CONSEQUENCE OF
(c) 3mo | | | | | | APPROXIMATE
BETWEEN ONSET AND DEATH
20878 | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1
None | | | | | | | |
| 19a. DATE OF OPERATION
None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE
John S. Rogers | | TITLE (SPECIFY)
M.D. Days | | MEDICAL EXAMINER | | DATE SIGNED
Jan 1, 1985 | |
| EXAMINER'S NAME
(TYPE OR PRINT)
JOHN S. ROGERS, M.D. | | ADDRESS
1919 Seminary Road, S.S.Md. 20910 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
Jan. 2, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Chambers Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Riverdale, P.G. Cty., Maryland | |
| 24. FUNERAL DIRECTOR
NAME
W.W. CHAMBERS Co., 8655 Georgia Ave., S.S. Md. | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 4 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "New York" and "United States" are faintly visible.]

RECEIVED
JAN 10 1964
FBI NEW YORK



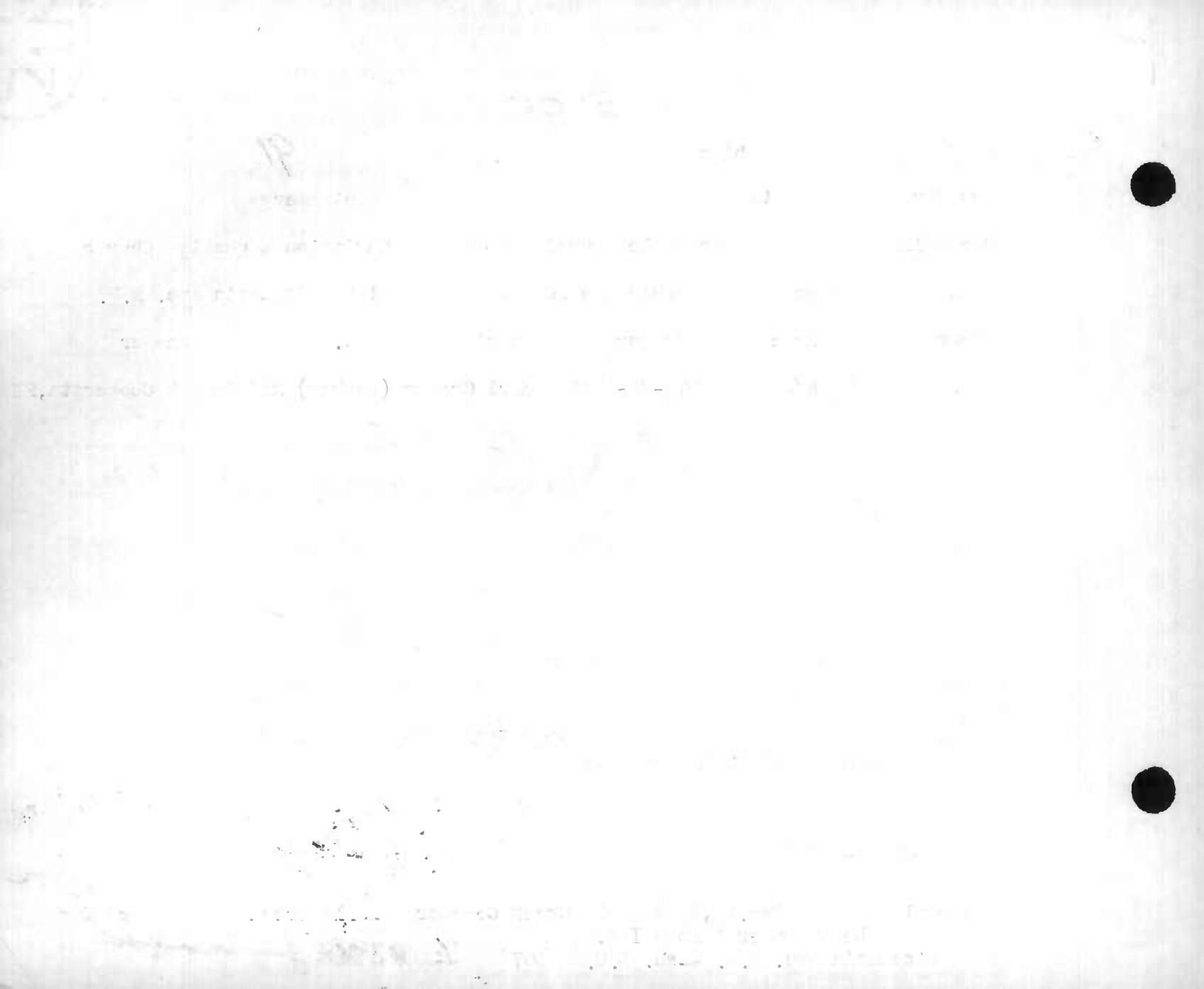
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 always has injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 33990 | |
|--|--|---|--|---|--|---|--|---|--|----------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) PEARL — Edna GROVER | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 12-8-84 | | 2b. HOUR— 8:05 A.M. | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 1 27 93 | | 6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Christian Education Church | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE None | | 13b. COUNTY None | | 13c. CITY OR TOWN Washington DC | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1255 Wisconsin Ave. N.W. 99999 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Edward None Grover | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl N. Seeger | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. N/A | | 17. INFORMANT ADDRESS Earl Grover (Nephew) RD2 Box 394 Cooperstn, NY | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Castro-intes tual bleeding
DUE TO, OR AS A CONSEQUENCE OF (c) 24 hrs.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 28 dec 19 84 to Jan 8 19 84 , that (I) (we) lost saw the deceased alive on 13 Nov 84 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Dr. Jean-Pierre FAURE | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED Dec 8-84 11 AM | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) FAURE JEAN. PIERRE | | | | 22e. ADDRESS 8218 Wisconsin Ave. Bethesda. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE Dec. 11, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY Fly Creek Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Fly Creek New York | | | | | |
| 24. FUNERAL DIRECTOR DeVol Funeral Home Inc NAME John F. DeVol ADDRESS 2222 Wisconsin Ave. N.W. Wash. D.C. 20007 DATE REC'D BY REGISTRAR DEC 3 1984 REGISTRAR'S SIGNATURE John F. DeVol | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|---|--|-----------------------------|--|
| <div style="text-align: right;">REG. NO. 33991</div> | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
NAN W. GUREN | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12/31/84 | | | 2b. HOUR
930 AM | | | |
| 3 SEX
FEMALE | | 4 RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
APRIL 1, 1906 | | 6 AGE (IN YEARS LAST BIRTHDAY)
78 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | | | | | | |
| 10 CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SUBURBAN HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | | 12b. KIND OF BUSINESS OR INDUSTRY
OWN HOME | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
BETHESDA | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
5225 POOKS HILL ROAD 20846 | | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
LOUIS WEINSTEIN | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
ANNA GOLDMAN | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
578-26-3574 | | 17. INFORMANT ADDRESS
LAURENCE GUREN, 8370 GREENSBORO DRIVE
McLEAN, VIRGINIA | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
48 HRS | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10 | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/30/84 to 12/31/84, that (I) (we) lost
saw the deceased alive on 12/30/84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
PENNY BISK LP | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12/31/84 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PENNY BISK LP | | | | 22e. ADDRESS
10313 GEORGIA AVE SUITE 200 SPRING MD | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
1/2/1985 | | 23c. NAME OF CEMETERY OR CREMATORY
KING DAVID MEMORIAL GARDEN | | | | 23d. LOCATION
CITY OR TOWN FALLS CHURCH, VIRGINIA | | | | |
| 24. FUNERAL DIRECTOR
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME
232 CARROLL STREET, N. W., WASHINGTON, D. C. | | | | | | | | | | | | |
| 25a. DATE RECD. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
JAN 4 1985 J. H. Davidson-Randall | | | | | | | | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 33992 | | | |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 1. DECEASED NAME (TYPE OR PRINT) Ola E. Guthrie | | | |
| 2a. DATE OF DEATH MONTH 12 DAY 13 YEAR 84 | | | | 2b. HOUR 10:30 P.M. | | | |
| 3. SEX F | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH 3 DAY 12 YEAR 29 | | 6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SILVER MANOR | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13a. STATE VIRGINIA | | 13b. CITY OR TOWN AUGUSTA | | 13c. STREET ADDRESS / ZIP CODE BOX 1208 23901 | | 13e. STREET ADDRESS / ZIP CODE 79999 | |
| 14. FATHER'S NAME FIRST WILLIAM MIDDLE GUTHRIE LAST TRENT | | | | 15. MOTHER'S MAIDEN NAME FIRST MARGARET MIDDLE TRENT LAST TRENT | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. N/A | | 17. INFORMANT ADDRESS 501 BEECH ST. CRAWFORD BRIGHTWELL, FARMVILLE, VA. 23901 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: ① Asthma ② Bronchitis ③ Mental Retardation | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH 12 DAY 5 YEAR 84 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN SILVER SPRING COUNTY MD. STATE MD. | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-5-84 , to Dec. 13, 1984 , that (I) (we) lost saw the deceased alive on 12-5-84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Alan R. Gair MD DEGREE MD | | | | 22c. DATE SIGNED 12/14/84 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN R Gair MD | |
| 22e. ADDRESS 11700 Old Columbia Pike Silver Spring, Md | | | | 22f. DATE REC'D. BY REGISTRAR DEC 19 1984 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 12/16/84 | | 23c. NAME OF CEMETERY OR CREMATORY 7TH DAY ADVENTIST CEM. | | 23d. LOCATION CITY OR TOWN CUMBERLAND COUNTY VA. STATE VA. | |
| 24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | 25. DATE REC'D. BY REGISTRAR DEC 19 1984 REGISTRAR'S SIGNATURE J. H. Davidson | | | |

15-1-1900

15-1-1900

15-1-1900

15-1-1900

X

15-1-1900

15-1-1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

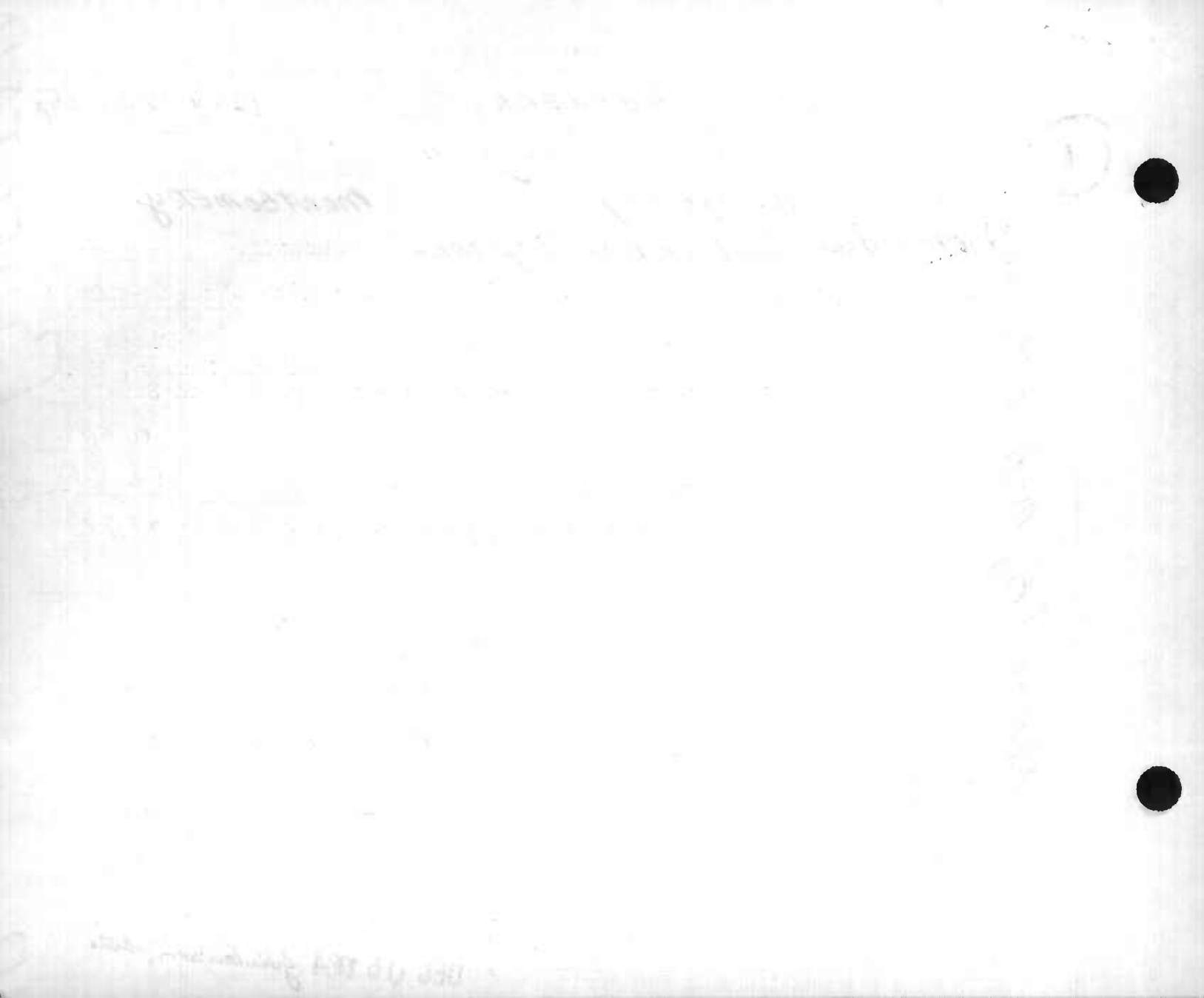
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Released By Medical Examiner

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 33993 | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--------------------------------|--|--------------------------------|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 12-1-84 | | | | | | | 2b. HOUR 1:55 PM | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) JABINA GUTWERK | | | | | 3. SEX Female | | | | | 4. RACE Cauc. | | 5. DATE OF BIRTH MONTH DAY YEAR 8-17-11 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS. HOURS MIN. | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland | | | | | 7b. CITIZEN OF WHAT COUNTRY? MONTGOMERY | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | | | | 12b. KIND OF BUSINESS OR INDUSTRY ----- | | | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | | 13b. COUNTY Montgomery | | | | | 13c. CITY OR TOWN Sil. Spg. | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET ADDRESS / ZIP CODE 8201 16th Street - 20910 | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Sam Naiman | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Plotnick | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NAME UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | | 16b. SOCIAL SECURITY NO. 578-01-2782 | | | | | 17. INFORMANT ADDRESS Silver Spring, Md. Nathan Gutwerk; 8201 16th Street | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) VENTRICULAR Fibrillation | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) Recurrent acute MYOCARDIAL INFARCT | | | | | | | | | | Sudden | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY Disease | | | | | | | | | | 10 yrs. | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 1a | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-6-84, to 12-1-84, that (I) (we) last saw the deceased alive on 11-6-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22b. SIGNATURE Herbert L. TAVENBAUM, MD | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12-1-84 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | 23b. DATE 12-4-1984 | | | | | 23c. NAME OF CEMETERY OR CREMATORY King David Mem. Gdn. Falls Church, Va. | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike | | | | | 25a. DATE REC'D. BY REGISTRAR 06-06-1984 | | | | | 25b. REGISTRAR'S SIGNATURE Julia Davidson | | | | | | | | | | | | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|--|---|---|--|--|---|--|---|--|
| 1- FOR STATE REGISTRAR | | | | | 33994
REG. NO. | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
HANNA S. HADDAD | | | | | 2a DATE OF DEATH MONTH DAY YEAR
12-15-84 | | | 2b HOUR
11 ¹⁵ A M | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
1 01 98 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
JORDAN | | 7b. CITIZEN OF WHAT COUNTRY?
JORDAN | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
CARPENTER | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
MARYLAND | | | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
SALAAMEH HADDAD | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
AUSLEH HADDAD | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | | | | 16b. SOCIAL SECURITY NO.
218-82-6430 | | 17 INFORMANT SON ADDRESS
12904 NEOLA ROAD WHEATON, MD. 20906 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 days | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____ | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/10/84 to 12/15/84, that (I) (we) lost (saw the deceased) (we) (did not) view the body after death. 12/15/84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. | | | | | | | | | | |
| 22b. SIGNATURE
B.N. ROSENBAUM, M.D. | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/15/84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
B.N. ROSENBAUM | | | | | 22e. ADDRESS
3720 FARRAGUT AVE.
KENSINGTON, MD. 2015 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
12/18/84 | | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | | 23d. LOCATION CITY OR TOWN COUNTY STATE
SILVER SPRING MONT MD. | | | |
| 24 FUNERAL DIRECTOR NAME
FRANCIS J. COLLINS | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 19 1984 | | | | | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | | | | | |



may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be filed within 72 hours after death.

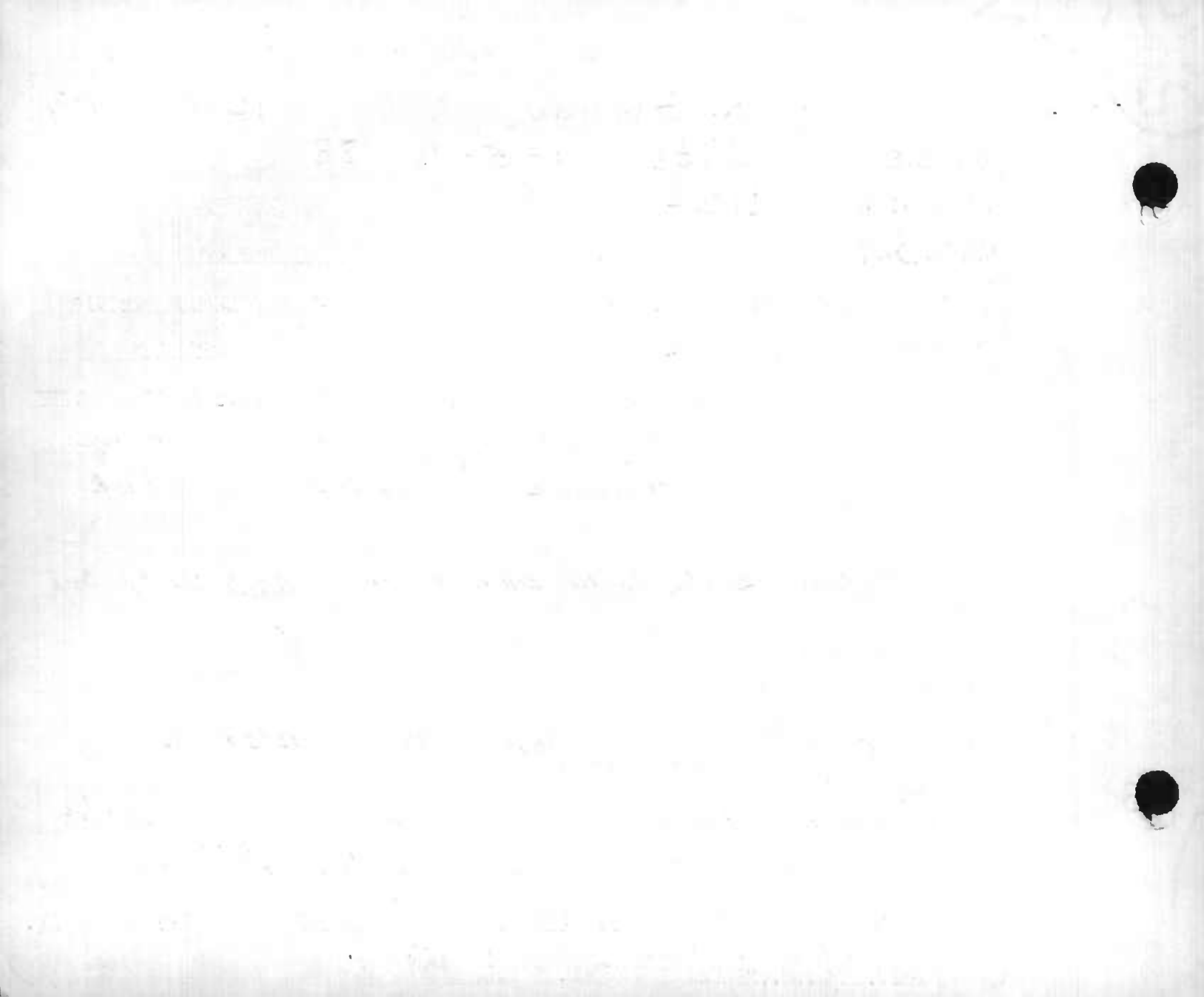
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 33995

| | | | | | |
|--|--|---|---|--|--|
| FOR
1. STATE
REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) <u>George H. Hamman</u> | | MONTH <u>12</u> DAY <u>29</u> YEAR <u>84</u> | | 150 <u>0</u> M | |
| 3. SEX
<u>Male</u> | 4. RACE
<u>white</u> | 5. DATE OF BIRTH
MONTH <u>1</u> DAY <u>5</u> YEAR <u>96</u> | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>88</u> YRS. | IF UNDER 1 YEAR
MONTHS <u></u> DAYS <u></u> | IF UNDER 24 HRS
HOURS <u></u> MIN. <u></u> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>VIRGINIA</u> | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>MONTGOMERY</u> MD. | | |
| 7c. <u>SILVER SPRING</u> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>HOLY CROSS HOSPITAL</u> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>POSTAL INSPECTOR</u> | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
<u>700 SLIGO AVENUE 20910</u> | | |
| 13a. STATE
<u>MARYLAND</u> | 13b. COUNTY
<u>MONTGOMERY</u> | 13c. CITY OR TOWN
<u>SILVER SPRING</u> | | | |
| 14. FATHER'S NAME
FIRST <u>DAVID</u> MIDDLE <u>W.</u> LAST <u>HAMMAN</u> | | 15. MOTHER'S MAIDEN NAME
FIRST <u>ALICE</u> MIDDLE <u></u> LAST <u>BEYDELER</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<u>YES</u> | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<u>WW I</u> <u>577-60-2727</u> | 17. INFORMANT
ADDRESS
<u>LENORE E. HAMMAN SAME AS 13 WIFE</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardio pulmonary failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Pneumonia, right lung</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u> | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>3 days</u>
<u>1 wk.</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
<u>Arterio sclerotic Cardiovascular disease - acute renal failure</u> | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<u></u> P.M. <u></u> <u></u> <u>19</u> | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>June</u> , 19 <u>70</u> , to <u>12/29</u> , 19 <u>84</u> , that (2) (we) last saw the deceased alive on <u>12/28</u> , 19 <u>84</u> , and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above (4) (we) (did) (and not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>James R. Coleman MD</u> | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
<u>12/29/84</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>JAMES R. COLEMAN</u> | | 22e. ADDRESS
<u>9241 COLUMBIA BLVD.</u>
<u>SILVER SPRING MD. 20910.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>BURIAL</u> | 23b. DATE
<u>12/31/84</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>FT LINCOLN</u> | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>BRENTWOOD PRI GEO MD.</u> | | |
| 24. FUNERAL DIRECTOR
NAME
<u>FRANCIS J. COLLINS</u> | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
<u>JAN 4 1985</u> <u>Davidson-Randall</u> | | | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REC NO. 33996

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
IDA BLANCHE HAMMER | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 26 1984 | | 7b. HOUR
P M
5:21 P | |
| 3. SEX
FEMALE | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH DAY YEAR
DECEMBER 5 1924 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
60 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MASSACHUSETTS | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
Home |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | 13b. CITY OR TOWN
CALVERT | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13d. STREET ADDRESS / ZIP CODE
3945 7th STREET 20714 | | 14. FATHER'S NAME
FIRST MIDDLE LAST
FRANK E. GODIN | | | |
| 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
BLANCHE ISABELL WHELPLEY | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | |
| 16b. SOCIAL SECURITY NO.
030-14-7029 | | 17. INFORMANT
ADDRESS
LEONARD L. HAMMER, 3945 7th STREET, NORTH BEACH, MD 20714 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) OVERWHELMING SEPSIS
DUE TO, OR AS A CONSEQUENCE OF
(c) PERFORATED DIVERTICULITIS | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: NO | | | | | |
| 19a. DATE OF OPERATION
26 DEC 1984 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
EXPLORATORY LAPARATOMY | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 16 , 19 84 , to DECEMBER 26 , 19 84 , that (I) (we) lost
saw the deceased alive on DECEMBER 26 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>H. R. Alexander</i> | | DEGREE
MD | | 22c. DATE SIGNED
27 Dec 84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
H. R. ALEXANDER, LCDR, MC, USNR | | 22e. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND,
NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/29/84 | | 23c. NAME OF CEMETERY OR CREMATORY
50. Memorial Gardens | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Dunkirk Calvert Md. | | 24. FUNERAL DIRECTOR
NAME ADDRESS
Rausch Funeral Home Owings, Md | | | |
| 25a. DATE REC'D. BY REGISTRAR
JAN 4 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | |



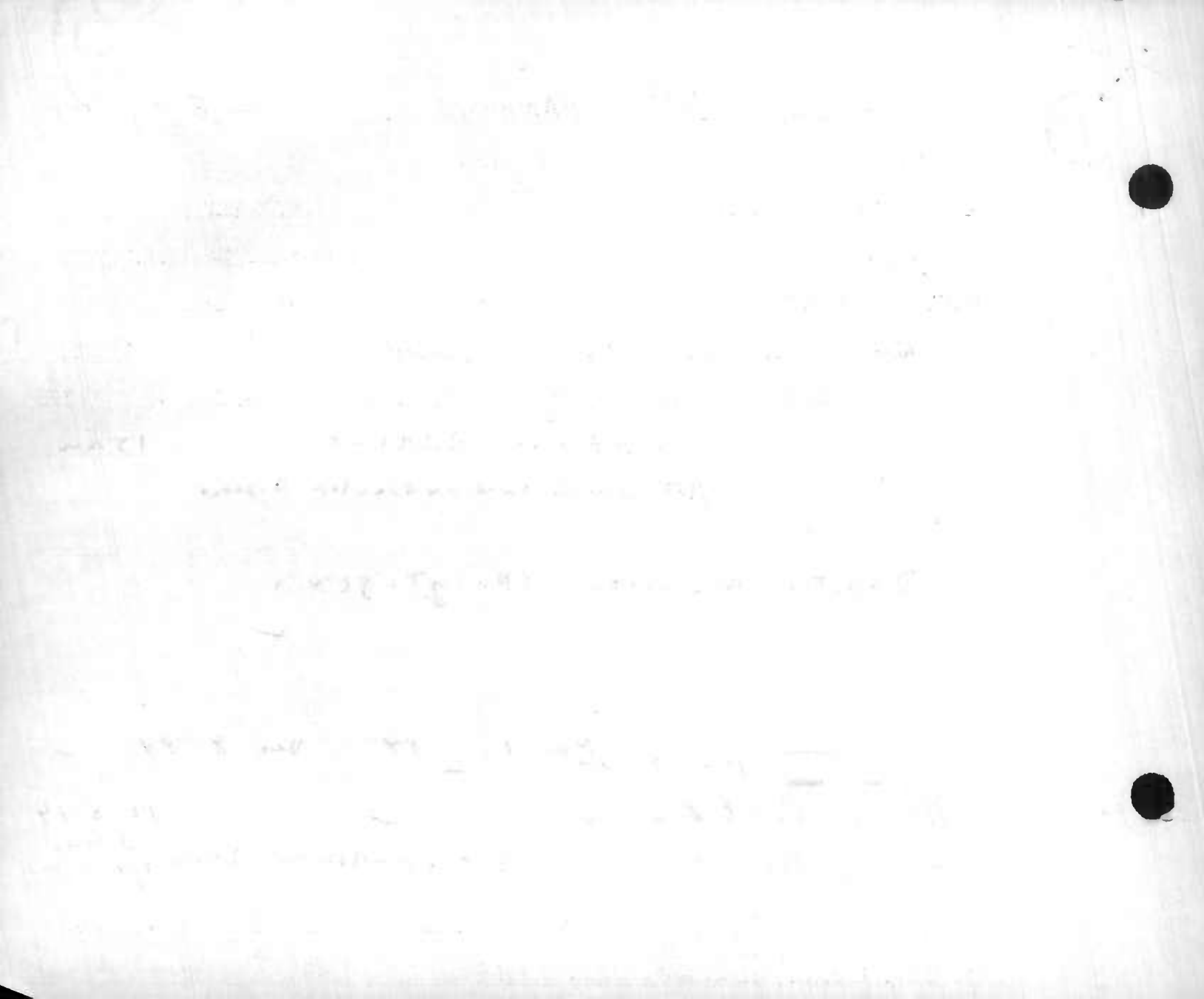
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 33991 | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | ALBERT EDWARD HAMMON, JR. | | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| MALE | | CAUCASIAN | | MAY 11, 1896 | | 88 YRS. | | 12 8 84 845 P M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| PENNSYLVANIA | | U.S.A. | | | | MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| KENSINGTON | | KENSINGTON GARDENS NURSING HOME | | | | TIRE SALESMAN | | B.F. GOODRICH CO | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | |
| MARYLAND | | MONTGOMERY | | ROCKVILLE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 6500 TILDEN LANE 20852 | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| ALBERT E. HAMMON, SR. | | | | GENEVIEVE WINKLE | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| YES | | | | WV I 578-01-9099 | | MARGARET E. HAMMON SAME AS 13 WIFE | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | 15 min |
| IMMEDIATE CAUSE (a) CARDIAC ARREST | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis Cardiovascular Disease | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes mellitus, PANCYTOGENIA | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET | | CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from Nov 1, 1984, to Dec 8, 1984, that (I) (we) lost the deceased alive on Nov 2, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | 22c. DATE SIGNED | | | |
| Morton Altschuler MD. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 12-8-84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | |
| Morton Altschuler MD. | | | | 1299-2 Ambrose Drive Spring, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | 23e. DATE REC'D. BY REGISTRAR | |
| BURIAL | | 12/12/84 | | ARLINGTON NATIONAL | | ARLINGTON | | DEC 13 1984 | |
| | | | | | | CITY OR TOWN COUNTY STATE | | 23f. REGISTRAR'S SIGNATURE | |
| | | | | | | | | Julia Davidson-Randall | |
| 24. FUNERAL DIRECTOR NAME | | | | 24b. ADDRESS | | 25. REGISTRAR'S SIGNATURE | | | |
| FRANCIS J. COLLINS | | | | 500 UNIV. BLVD., W. SILVER SPRING, MD. 20901 | | DEC 13 1984 | | | |

BP



DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 3 3 9 9 8

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|---|----------------------|---|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Lillian McCray Harris | | | 20. DATE KNOWN OF DEATH
ESTIMATED Dec 10 1984 | | | 26. DATE OF DEATH
MONTH DAY YEAR Dec 11 1984 | | |
| 3. SEX
F | 4. RACE
Bk | 5. DATE OF BIRTH
MONTH DAY YEAR July 2, 1926 | 6. AGE (IN YEARS)
LAST BIRTHDAY 58 | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | 7. DATE PRONOUNCED DEAD
Dec 11 1984 | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2205 Osborn Dr | | | | 12c. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
MD | | | | 13b. CITY OR TOWN
Bethesda | | 13c. STREET ADDRESS
2205 Osborn Dr | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Will McCray | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Katie McCray | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
578 38 0421 | | 17. INFORMANT
ADDRESS
Stewart Harris-son-2205 Osborn Dr | | | | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Disi
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

| | | |
|--|---|---|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
None | | |
| 19a. DATE OF OPERATION
None | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE |

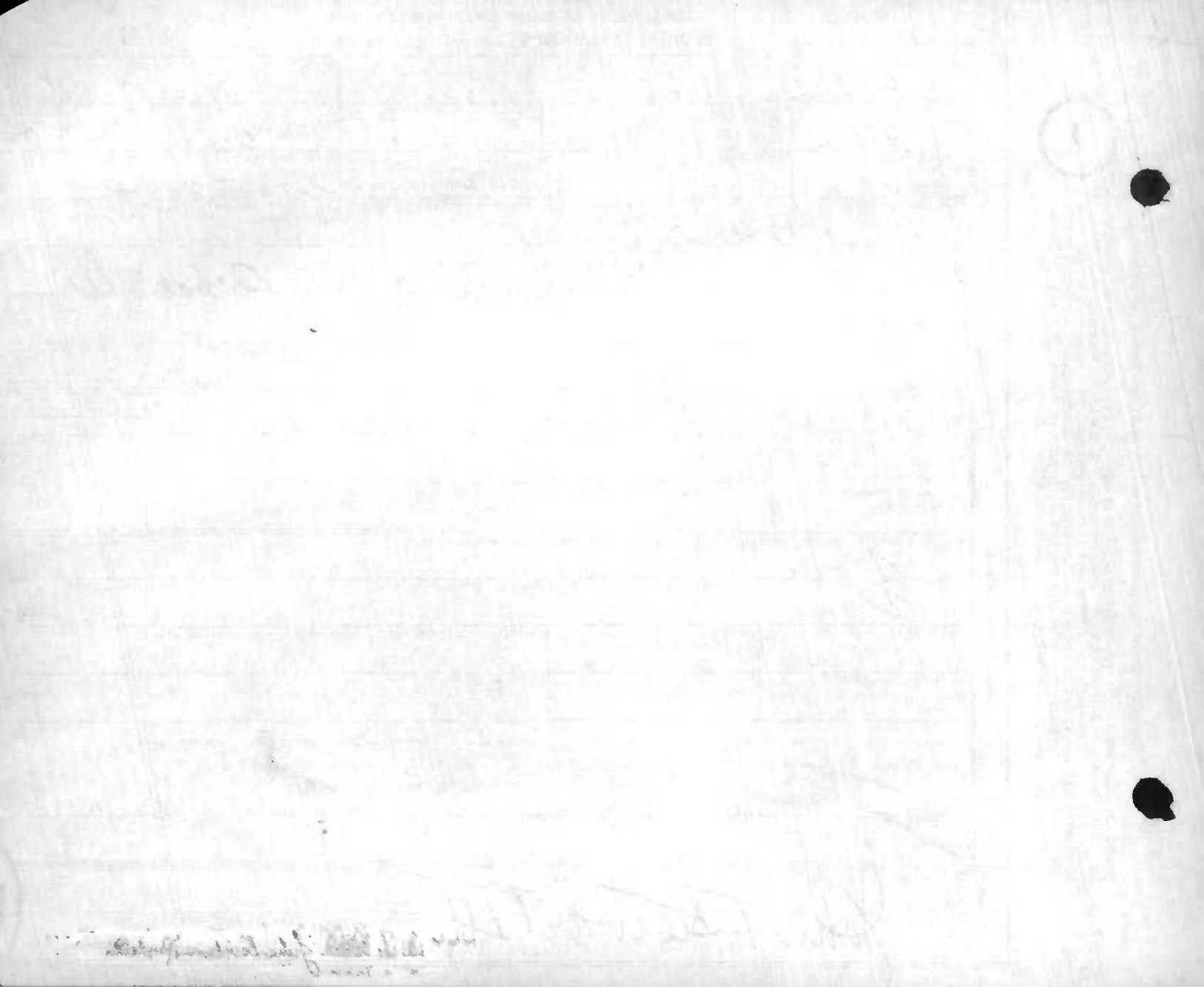
| | | |
|--|-------------------------------|----------------------------|
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | |
| ACTUAL SIGNATURE
[Signature] | TITLE (SPECIFY)
Dep | DATE
Dec 11 1984 |
| EXAMINER'S NAME
(TYPE OR PRINT)
[Signature] | ADDRESS | |

| | | |
|--|--|---|
| 23a. BURIAL, CREMATION, REMOVAL, 23b. DATE
(SPECIFY)
Burial Dec. 15, 1984 | 23c. NAME OF CEMETERY OR CREMATORIUM
Harmony Memorial Park | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Landover, Maryland |
| 24. FUNERAL DIRECTOR
NAME
Stewart Funeral Home-4001 Benning Rd | | 25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
DEC 17 1984 Julia Davidson-Rodden |

BP _____

DHMH - 17
(VR A15 ME (5))
20M 4/82

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. IF THE DEATH IS SUSPECTED, THE MEDICAL EXAMINER SHOULD BE NOTIFIED IMMEDIATELY. IF THE DEATH IS SUSPECTED, THE MEDICAL EXAMINER SHOULD BE NOTIFIED IMMEDIATELY. IF THE DEATH IS SUSPECTED, THE MEDICAL EXAMINER SHOULD BE NOTIFIED IMMEDIATELY.



BP

DHMH - 16 50M 4/82
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| Item 4 per phone 12/20/84 dad | | | | STATE OF MARYLAND | | | |
| FOR
1 - STATE REGISTRAR | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST
Jeanette R. Hartung | | | | 2c. DATE OF DEATH MONTH DAY YEAR 2b. HOUR
12 13 84 10 ⁵⁵ AM | | | |
| 3. SEX
F | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
2 5 97 | | 6. AGE (IN YEARS LAST BIRTHDAY)
37 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Kentucky | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Potomac Valley Nursing Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | 13b. COUNTY
Montg. | | 13c. CITY OR TOWN
Chevy Chase | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Charles D. Tedrow | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Jeanette Ricketts | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
13e. STREET ADDRESS
3709 Leland Street 20815 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
217-32-1958 | | 17. INFORMANT ADDRESS
Elizabeth Crenshaw, 2901 N. 26th St.,
Arl., VA 22207 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 DAYS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis. Chronic Bronchitis</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/20/84</u> to <u>12/13/84</u> , that (I) (we) lost
saw the deceased alive on <u>12/20/84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Henry C. Scruggs</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/13/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HENRY C. SCRUGGS M.D. | | | | 22e. ADDRESS
5413 Cedar Lane Bethesda Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/17/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Rock Creek Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, DC | |
| 24. FUNERAL DIRECTOR NAME
Hines/Rinaldi Funeral Home | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 17 1984 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |
| 11800 New Hampshire Avenue, Silver Spring, MD | | | | | | | |

21

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO. 34000

| | | | | | | | |
|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) CHRISTOPHER LEE (OLIVER) | | | 7a. DATE OF DEATH
MONTH 12 - DAY 23 - YEAR 84 | | | 7b. HOUR
3:45 P.M. | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH 12 - DAY 23 - YEAR 84 | | 6. AGE (IN YEARS LAST BIRTHDAY)
0 YRS | |
| 7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7d. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
N/A | |
| 13a. STATE
MARYLAND | | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | |
| 14. FATHER'S NAME
FIRST ENALDO MIDDLE F LAST HAWKINS | | | | 15. MOTHER'S MAIDEN NAME
FIRST SHERMA MIDDLE W LAST OLIVER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT
ADDRESS
SHERMA OLIVER (MOTHER) SAME AS #13 | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CARDIO-RESPIRATORY ARREST**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **SEVERE PREMATURE (22 wks)**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/23/84 to 12/23/84 , that (I) (we) lost
saw the deceased alive on 12/23/84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
A. Gebreselassie | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/23/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A. GEBRESELASSIE | | | | 22e. ADDRESS
HOLY CROSS HOSPITAL | | | |

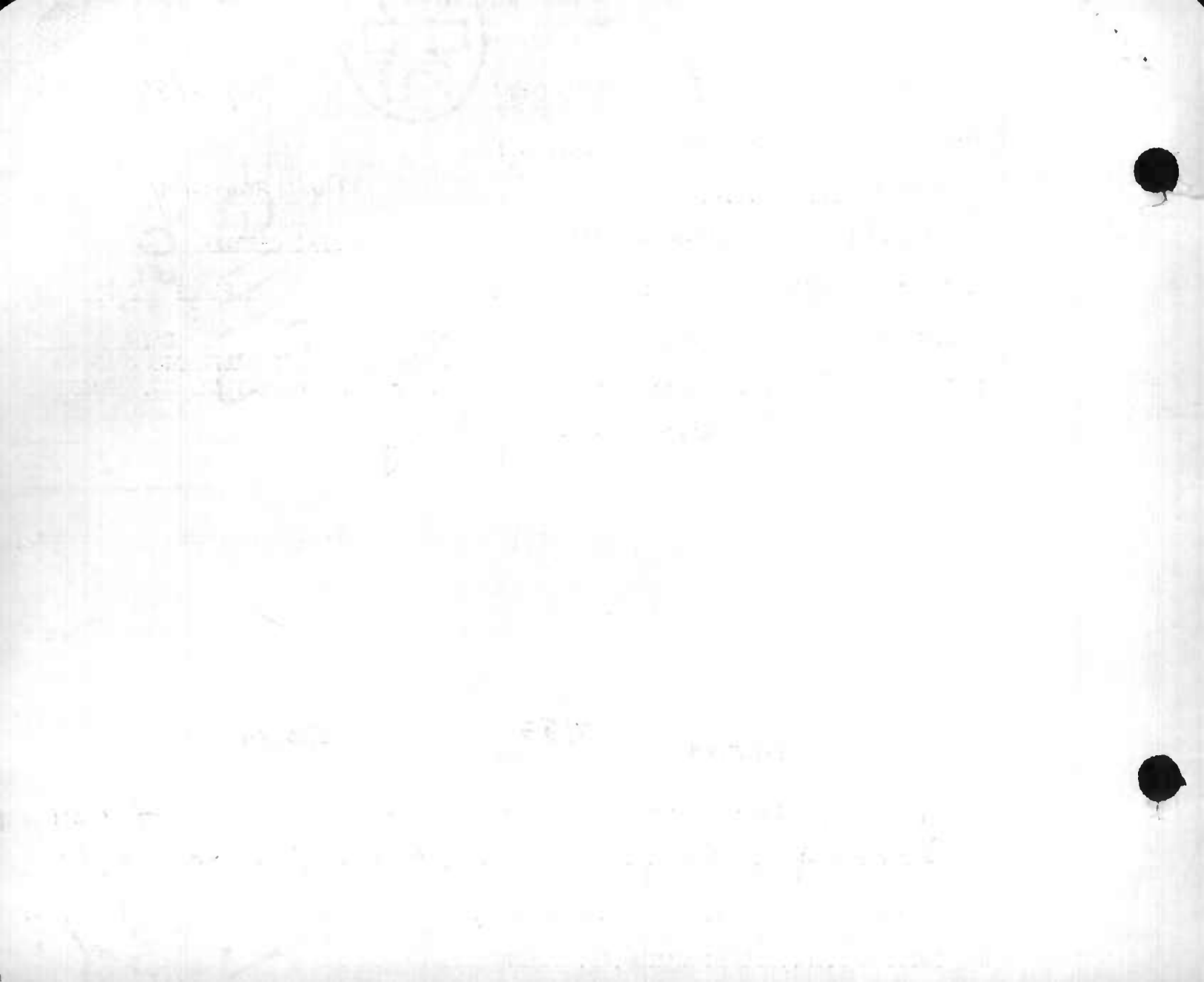
| | | | | | | | |
|---|--|-----------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | | 23b. DATE
DEC. 26, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
CHAMBERS CREMATORY RIVERDALE P.G. CO. MARYLAND | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR
NAME
CHAMBERS FUNERAL HOME SILVER SPRING, MD. | | | | 25. DATE OF DEATH
DEC 31 1984 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR
1 - STATE
REGISTRAR | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | REG. NO. 34001 | |
|---|-----------------------------|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Bernard S. Hayden | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/16/84 | | 2b. HOUR
248^{AM} | |
| 3. SEX
MALE | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH DAY YEAR
SEPT 5, 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASHINGTON, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
POSTAL CARRIER | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
ROCKVILLE | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
BERNARD | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ANNA CAIN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
YES WW II | | 16b. SOCIAL SECURITY NO.
578-14-5594 | | 17. INFORMANT
DAUGHTER ROSEMARY HAYDEN | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of lung
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 18a. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/83 , 19____, to 12/16/84 , 19____, that (I) (we) lost
saw the deceased alive on 12/15/84 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 27b. SIGNATURE
Jeremy V. Cooke | | DEGREE
MD | | 27c. DATE SIGNED
12/16/84 | |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)
Jeremy V. Cooke | | 27e. ADDRESS
10400 Penn. Ave. Kensington | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12/18/84 | | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
SILVER SPRING MONT MD. | | 23e. DATE RECEIVED BY REGISTRAR | | | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS | | ADDRESS
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

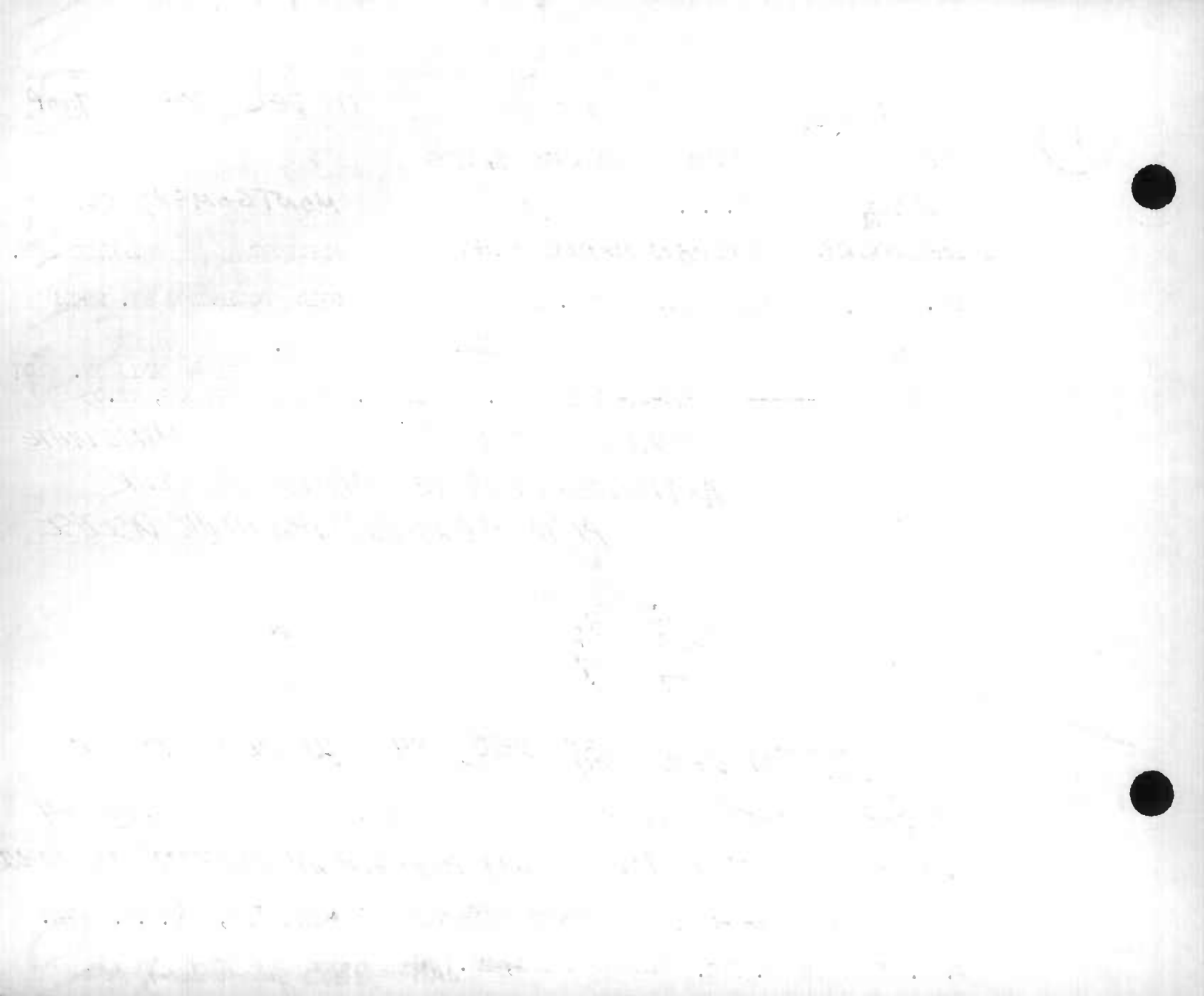
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as having been seen, any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. 34002 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) WILLIAM HAYNES | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 31 DEC 84 | | | 2b. HOUR 7:00 P.M. | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR JUNE 5, 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD. | | | |
| 10. CITY OR TOWN OF DEATH SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SYLVAN MANOR N.H. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARPENTER | | 12b. KIND OF BUSINESS OR INDUSTRY BUILDING IND. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 13a. STATE MD. | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN SILVER SPR. | | 13e. STREET ADDRESS / ZIP CODE 2314 ECCLESTON ST. 20910 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST HENRY HAYNES | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY O. TALLEY | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 578-07-9303 | | 17. INFORMANT ADDRESS RD 4 MAIN ST. #107 MILTON, VT. 05468 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR AND CEREBROVASCULAR DISEASE
DUE TO, OR AS A CONSEQUENCE OF (c) AND CEREBROVASCULAR DISEASE
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) WALTER E. GOOZH MD attended the deceased from 20 DEC 1984 to 31 DEC 1984 that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 21 DEC 1984 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) WALTER E. GOOZH MD did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE WALTER E. GOOZH MD | | | | DEGREE MD | | | | 22c. DATE SIGNED 31 DEC 84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOOZH MD | | | | 22e. ADDRESS 2309 SHOREFIELD RD WHEATON MD 20902 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE 1-4-1985 | | 23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE, P.G.C. Md. | | | |
| 24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO. INC. | | | | ADDRESS SILVER SPRING, MD. | | 15a. DATE REC'D. BY REGISTRAR 15b. REGISTRAR'S SIGNATURE JAN 9 1985 | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. 34003 | | |
|---|--|--|--|--|----------------|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Thomas J. Hearton | | | | 12 23 84 | | 12:20 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Male | | Caucasian | | 9 24 01 | | 83 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Maryland | | U.S.A. | | | | Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Rockville | | Shady Grove Adventist Hospital | | Retired-USNRb. | | Federal Gov't. | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Md | | PG. | | Forest Hts, Md. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13e. STREET ADDRESS | | 20745 | |
| Thomas J. Hearton | | Laura Farnsworth | | 113 Seneca Dr. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 5150 Kimscoot Ct. Annandale, Va. | |
| No | | 214-05-9204 | | Leonard Hearton | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>cardiac arrest</u> | | | | | | | 50 min |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>ischemic heart disease</u> | | | | | | | 16 years |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>cerebrovascular disease</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 12-23 19 84, to 12-28 19 84, that (1) (we) lost saw the deceased alive on 12-23 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | |
| Neil A. Crane | | | | MD | | 12/23/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| Neil A. Crane, MD | | | | 5400 Wisconsin Ave Chevy Chase, Md 20815 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Burial | | 12/28/84 | | Hillcrest Cemetery | | Cumberland Allegany Maryland | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| George P. Kalas Funeral Home Oxon Hill, Md. | | | | DEC 28 1984 | | C Davidson | |

BP _____



12/23/81

Assistant Secretary

Cambridge, Maryland

8160 Oxon Hill Rd.

George F. Baker Trust Home Oxon Hill, Md.

Rockville

Grady Grove Adventist Hospital

Montgomery

11/11/81
20712

Thomas

1.

Heaton

Heaton

2150 Lincoln Ct.
Arlington, Va.

Edward Heaton

Princeton

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP _____
DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 34004

| | | | | | | | | | | | | | |
|--|-------------------------|---|---|---|--|---|--|---|--|---|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME
[TYPE OR PRINT] Vivian C. Heaton | | | | | | | | | | EST. MATED XX 6/24/ 1984 | | M 1:30
P M | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH Apr DAY 6 YEAR 1911 | 6. AGE (IN YEARS)
LAST BIRTHDAY 73 YRS. | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 7c. DATE PRONOUNCED DEAD
11/29/ 1984 | | 7d. HOUR | | P M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New Hampshire | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Chestnut Lodge Grounds & Rt. 270 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife (ret) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
Rockville Nursing Home | | | | | |
| 14. FATHER'S NAME
FIRST James MIDDLE Cummings LAST Cummings | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST Anne MIDDLE Mahoney LAST Mahoney | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) no | | | | 16b. SOCIAL SECURITY NO.
251 16 6210 | | 17. INFORMANT ADDRESS
Lillian M. Jarry, Warsaw, Va. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Gregory R. Kauffman | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 11/30/84 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. | | | | ADDRESS 111 Penn St. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
CREMATION | | | | 23b. DATE
Dec 4 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Crematory | | | | 23d. LOCATION
CITY OR TOWN Bethesda COUNTY MD STATE MD | | | |
| 24. FUNERAL DIRECTOR
NAME Takoma Funeral Home, J.C. Waller ADDRESS 237 Carroll St NW D C U E 05 1084 | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | | |

DATE, TIME, AND PLACE OF BIRTH

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH34005
REG. NO.1- FOR
STATE
REGISTRAR

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) HEBDEN, WILLIAM NMN | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 11, 1984 | | 2b. HOUR
M |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
APRIL 18, 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENNSYLVANIA | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. |
| 10. CITY OR TOWN OF DEATH
TAKOMA PARK | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
WASHINGTON ADVENTIST HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
COAL MINER AND | 12b. KIND OF BUSINESS OR INDUSTRY
CARPENTER |
| 13a. STATE
VIRGINIA | | 13b. COUNTY
RICHMOND | 13c. CITY OR TOWN
FONESWOOD | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ALBERT | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
BESSIE BERKEY | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II | 17. INFORMANT
WIFE SAME AS | 17a. ADDRESS
17300 WALKER BLVD. #100 |
| | | 17b. NAME
JEANETTE S. HEBDEN | 17c. ADDRESS
17300 WALKER BLVD. #100 | 17d. ADDRESS
17300 WALKER BLVD. #100 |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) **PNEUMONIA, RESPIRATORY FAILURE**

DUE TO, OR AS A CONSEQUENCE OF

(b) **EMPHYSEMA**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c) **CHRONIC OBSTRUCTIVE LUNG DISEASE**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1 MONTH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

GASTROINTESTINAL BLEEDING

| | | | |
|--|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from 11/10 , 19 84 , to 12/10 , 19 84 , that (I) (we) last saw the deceased alive on 12/10 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Joseph B. Mizgerd, MD | DEGREE
MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
12/11/84 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOSEPH B. MIZGERD MD | | 22e. ADDRESS
7600 CARROLL AVE., TAKOMA PARK, MD 20912 | |

| | | | |
|---|------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | 23b. DATE
12/13/84 | 23c. NAME OF CEMETERY OR CREMATORY
FT. LINCOLN CEMETERY | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BRENTWOOD PRI GEO MD. |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | 25a. DATE REC'D. BY REGISTRAR
DEC 17 1984 | 25b. REGISTRAR'S SIGNATURE
Lia Davidson-Randall |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 34006

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|---|--|---|-----------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
JAMES W HEENAN, SR | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 16 - 84 | | 2b. HOUR
10:30 AM | | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
7 18 13 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS.
IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW JERSEY | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
STALLSMAN | | 12b. KIND OF BUSINESS OR INDUSTRY
BAKERY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE
MD | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
WHEATON | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
12814 HOLDRIDGE ROAD 20906 | | 14. FATHER'S NAME
FIRST MIDDLE LAST
ARTHUR HEENAN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ELLEN CAHILL | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II | | 17. INFORMANT
EDNA L. HEENAN | | ADDRESS
SAME AS 13 WIFE | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **RESPIRATORY ARREST**

DUE TO, OR AS A CONSEQUENCE OF

(b) **LARYNGOTRACHEAL OBSTRUCTION**

DUE TO, OR AS A CONSEQUENCE OF

(c) **METASTATIC CARCINOMA (UNDIFFERENTIATED) OF MEL. 2 1/2 YRS**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

NO

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 19a. DATE OF OPERATION
11/17/84 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
METASTATIC CARCINOMA OF MEL. 2 1/2 YRS | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/17/84 19 84 to 12/16 19 84 , that (I) (we) last saw the deceased alive on 12/16 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Robert J. Bohannon | | | | DEGREE
MD | | 22c. DATE SIGNED
12/16/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT J. BOHANNON | | | | 22e. ADDRESS
8830 CAMDEN STREET S.S. MD | | | |

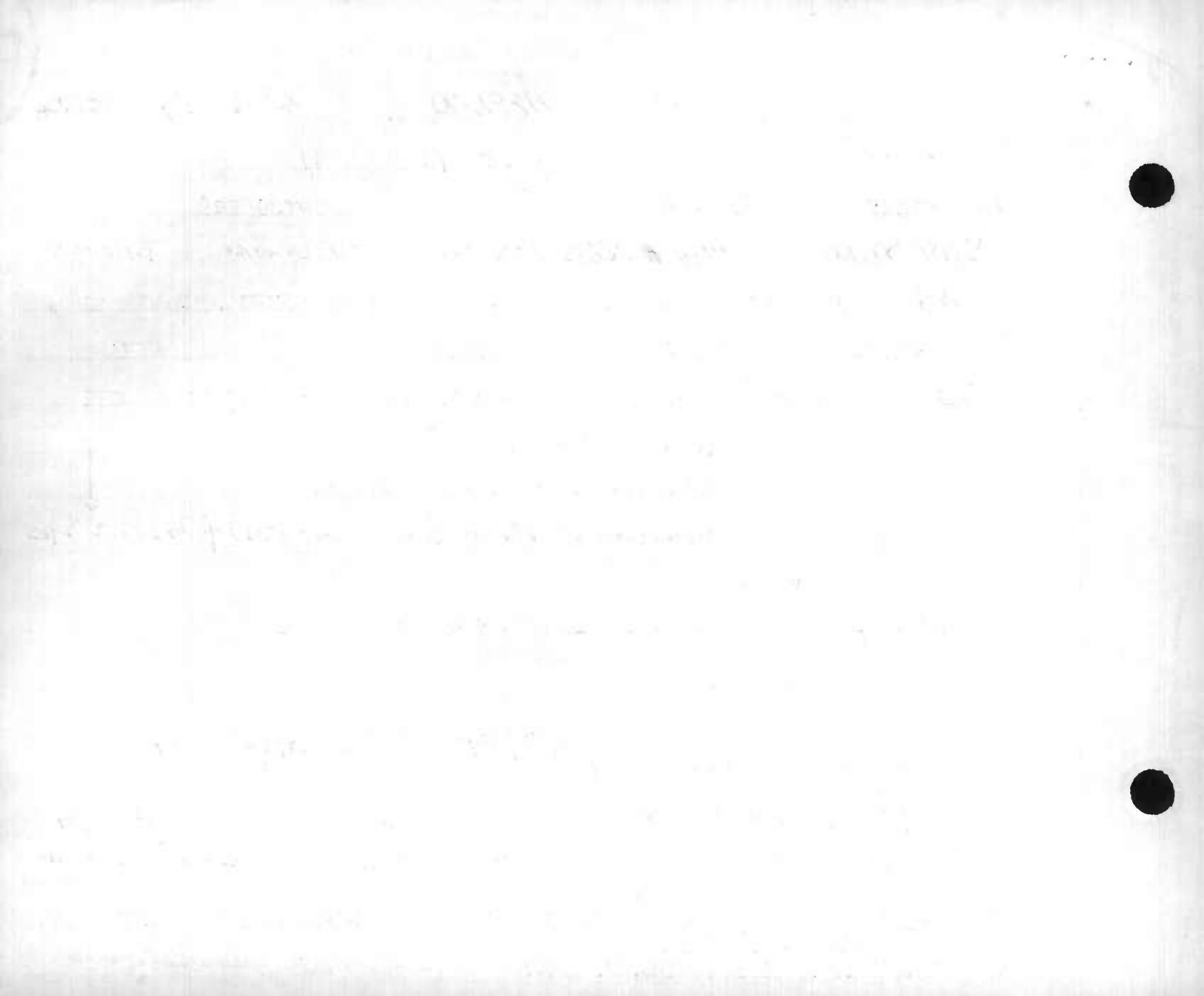
| | | | | | | | |
|---|--|------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12/20/84 | | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
SILVER SPRING MONT MD. | |
| 24. FUNERAL DIRECTOR
NAME FRANCIS J. COLLINS ADDRESS 900 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | 25a. DATE REC'D. BY REGISTRAR DEC 19 1984 25b. REGISTRAR'S SIGNATURE Jana Davidson-Vandell | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please sign and return to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|---|
| 1. FOR STATE REGISTRAR | | REG. NO. 34007 | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR 7b. HOUR | |
| Matilda | | | | | | Helfgott | | 12 27 84 9:55p M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| Female | | White | | Aug. 4, 1910 | | 74 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Michigan | | USA | | | | Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | |
| Bethesda | | Suburban Hospital | | | | | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Homemaker | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | |
| Florida | | Broward | | Tamarac | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 6602 N.W. 74th Ave. 33319 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | | | |
| Samuel | | Maxman | | Anna Galion | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | |
| No | | 374-12-3855 | | 8815 Stonehaven Court Mrs. Irv (Lue) Maggin; Potomac, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Suspected myocardial infarction</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 hour</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>30 MINUTES</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>ASCVD</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| 0 | | 0 | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| | | 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | 12/27 | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>12/27</u> 19 <u>84</u> , to <u>12/27</u> 19 <u>84</u> , that (1) <u>we</u> lost saw the deceased alive on <u>12/27</u> 19 <u>84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) <u>we</u> (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | |
| <u>Raymond Bass</u> | | MD | | 12-27-84 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| RAYMOND BASS | | 3925 Fernau Rd Wheaton Md 20906 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | 12-31-1984 | | Adat Shalom Mem. Park | | Livonia, Mich. | | | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Danzansky-Goldberg Chapels; 1170 Rockville Pike | | JAN 02 1985 | | <u>John Davidson-Rodella</u> | | | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH34008
REG. NO.

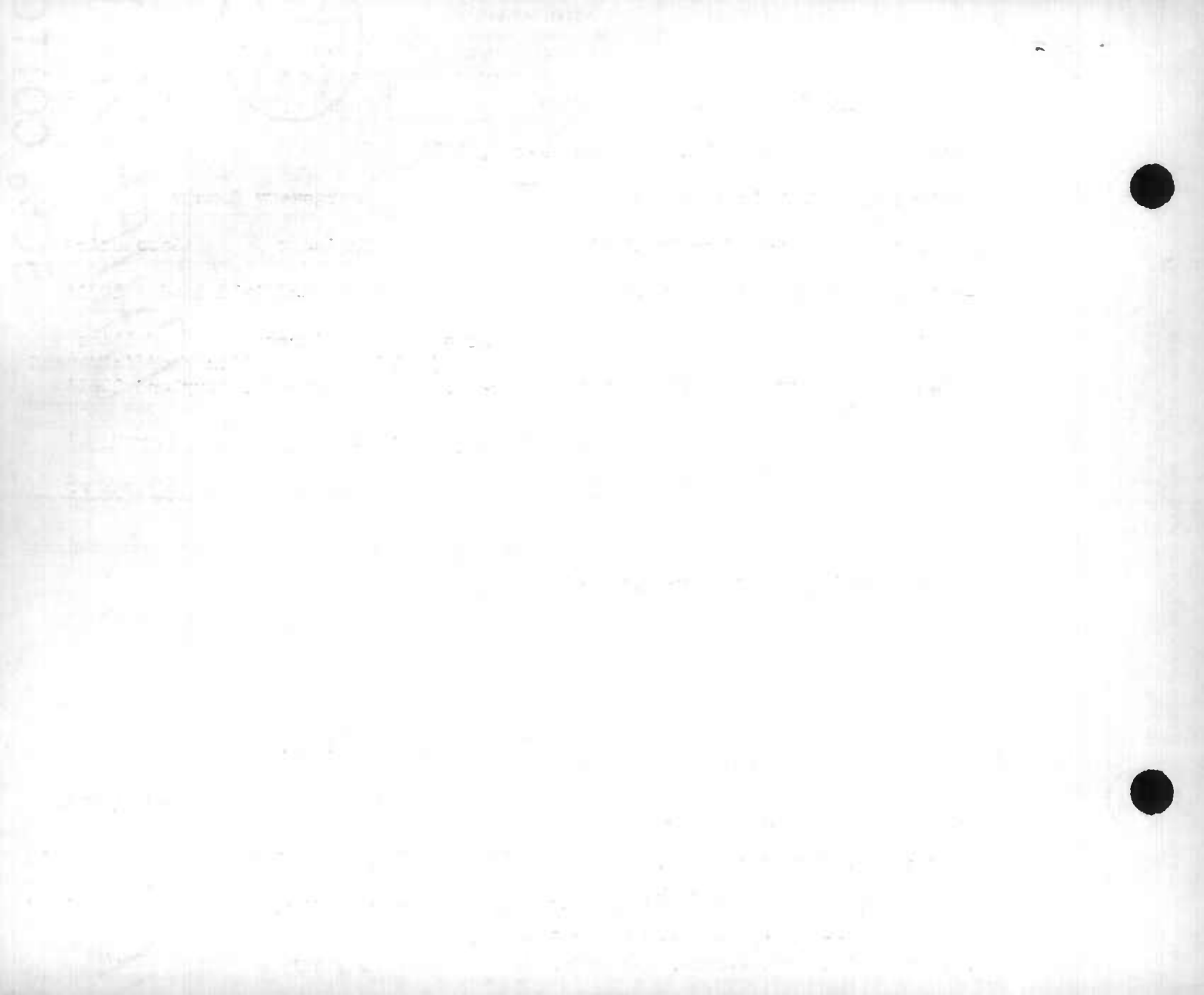
| | | | | | |
|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 7b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | A M | |
| FIRST MIDDLE LAST | | December 6, 1984 | | 8:14 | |
| Jeremiah C. Hege | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR IF UNDER 24 HRS | |
| Male | Caucasian | October 5, 1920 | 64 | MONTHS DAYS | HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Washington, D.C. | United States | | Montgomery County MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Bethesda | Suburban Hospital | Engineer | Aeronautics | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | |
| Maryland | Montgomery | Bethesda | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 4632 Woodfield Road 20814 | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | | | | |
| FIRST MIDDLE LAST | FIRST MIDDLE LAST | | | | |
| Edwin S. Hege | Lena Agnes Collins | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) | 17. INFORMANT (Wife) ADDRESS | | | |
| Yes | WWII | 4632 Woodfield Road | | | |
| | 577-40-0221 | Betty D. Hege, Bethesda, Maryland 20814 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-respiratory Arrest | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Terminal |
| DUE TO, OR AS A CONSEQUENCE OF (b) ASHD & HCVD | | | | | 20 years |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (10) | | | | | |
| Generalized Atherosclerosis | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov. 19, 1984, to Dec. 6, 1984, that (I) (we) lost
saw the deceased alive on Dec. 5, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| <i>George F. Sengstack</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | December 6, 1984 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| George F. Sengstack M.D. | | 9241 Columbia Blvd, Silver Spring, MD 20910 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION | | |
| Burial | December 10, 1984 | Gate of Heaven Cemetery | Silver Spring Maryland | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Robert A. Pumphrey Funeral Homes,
P.A. 7557 Wisconsin Avenue, Bethesda, MD | | DEC 10 1984 | | <i>Julia Davidson</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH IN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 34009 | |
|---|--|--|--|--|--|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | 7a. DATE KNOWN OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) Richard Heidemann | | | | | | | | | | Dec 22 1984 | |
| 3. SEX M 4. RACE W 5. DATE OF BIRTH (MONTH DAY YEAR) Feb 3 31 83 6. AGE (IN YEARS) (LAST BIRTHDAY) 51 7. IF UNDER 1 YR. IF UNDER 24 HRS. | | | | | | | | | | 7b. DATE OF DEATH ESTIMATED Dec 22 1984 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin 7b. CITIZEN OF WHAT COUNTRY? United States 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD | |
| 10. CITY OR TOWN OF DEATH Olney 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mont. General Hosp 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Broker 12b. KIND OF BUSINESS OR INDUSTRY Real Estate | | | | | | | | | | 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md 13c. CITY OR TOWN Montgomery 13d. INSIDE CITY LIMITS? YES 13e. STREET ADDRESS 5213 Waterview Dr. | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) Milton Heidemann 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Mabel Brey | | | | | | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes 16b. SOCIAL SECURITY NO. Unknown 17. INFORMANT Anna L. Heidemann ADDRESS 5213 Waterview Drive Rockville, Maryland 20853 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION None 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE John S. Rogers M.D. Dep MEDICAL EXAMINER DATE SIGNED Dec 22, 1984 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers ADDRESS 1919 Seminary Rd., Silver Spring, MD | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE December 24, 1984 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery 23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Robert A. Pumphrey ADDRESS Funeral Homes PA 300 West Montgomery Ave Rockville Md. 20850 25a. DATE REC'D. BY REGISTRAR DEC 24 1984 25b. REGISTRAR'S SIGNATURE John S. Rogers | | | | | | | | | | | |



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BP

DHMH - 16 50M 4/83
(VRA 15, 4)

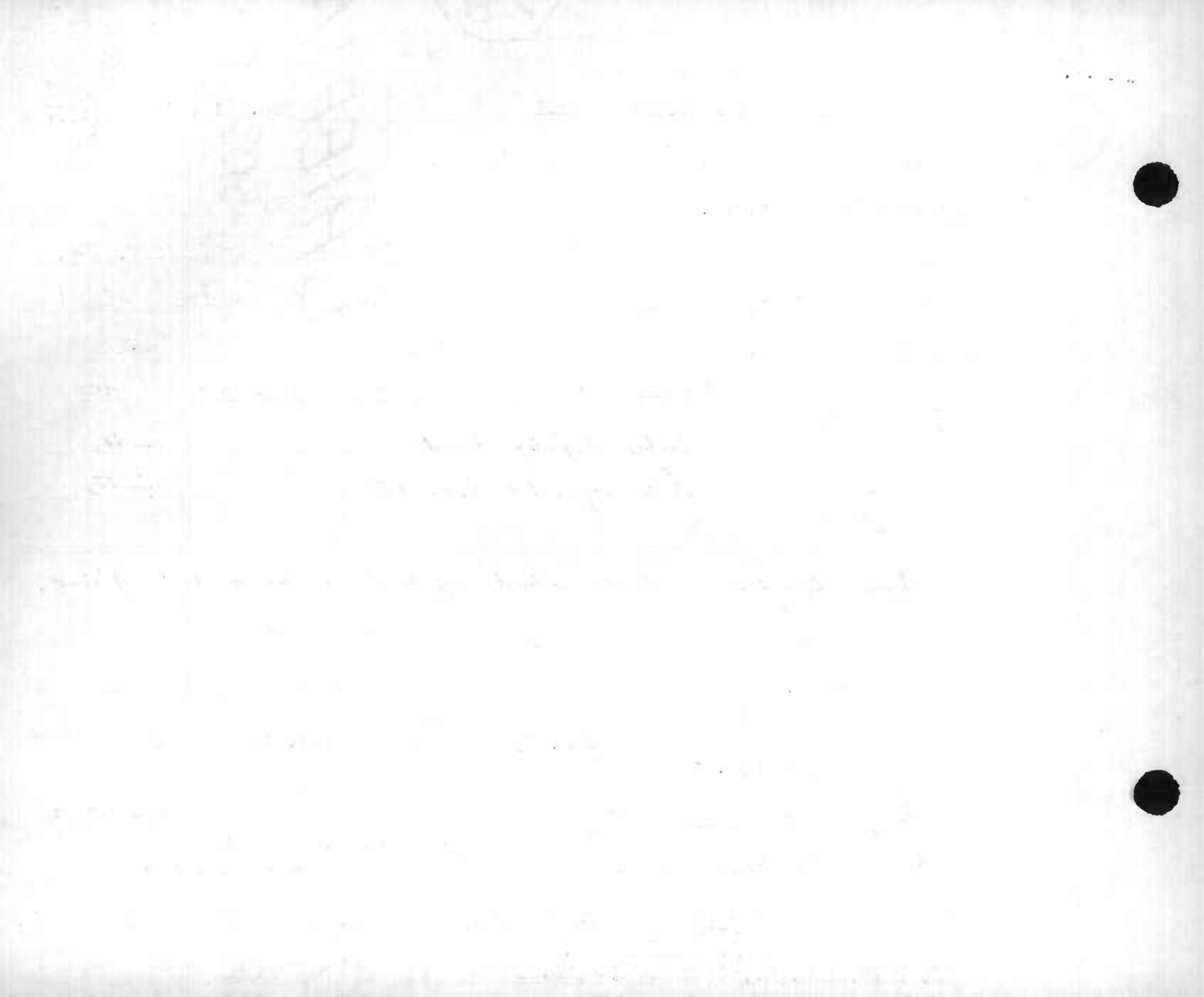
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | REC. NO. 34010 | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Dick Christopher Heil | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
Dec. 17, 1984 | | | 2b. HOUR
11:55P M | | |
| 3. SEX
Male | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR
05 14 25 | | 6. AGE (IN YEARS LAST BIRTHDAY)
59 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SUBURBAN HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
PRESIDENT KAPPE | | 12b. KIND OF BUSINESS OR INDUSTRY
ASSO., INC. | | |
| 13a. STATE
MARYLAND | | | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
WILLIAM B. HEIL | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
JULIA MYERS | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
181-24-4379 | | 17. INFORMANT
PAULINE R. HEIL | | ADDRESS
SAME AS 13 | | WIFE | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Respiratory Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Acute Myocardial Infarction</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>minutes</u>
<u>minutes</u> | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:
<u>Chronic Coronitis. Labile Arterial Hypertension. Corary Arteriosclerosis.</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan. 15</u> , 19 <u>69</u> , to <u>Oct. 19</u> , 19 <u>84</u> , that (I) (we) lost
saw the deceased alive on <u>Oct. 19</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Hugo E. Graziani</u> 30 | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12-18-84 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HUGO E. GRAZIANI | | 22e. ADDRESS
717 NORTON DR.
S-S- MD 20910 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
12/21/84 | | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
SILVER SPRING MONT MD. | | | | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS | | 24a. DATE REC'D. BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE
Julia Davidson-Rodale | | | | | | |
| 500 UNIV. BLVD. W. SILVER SPRING, MD. 20901 | | DEC 24 1984 | | | | | | | | |



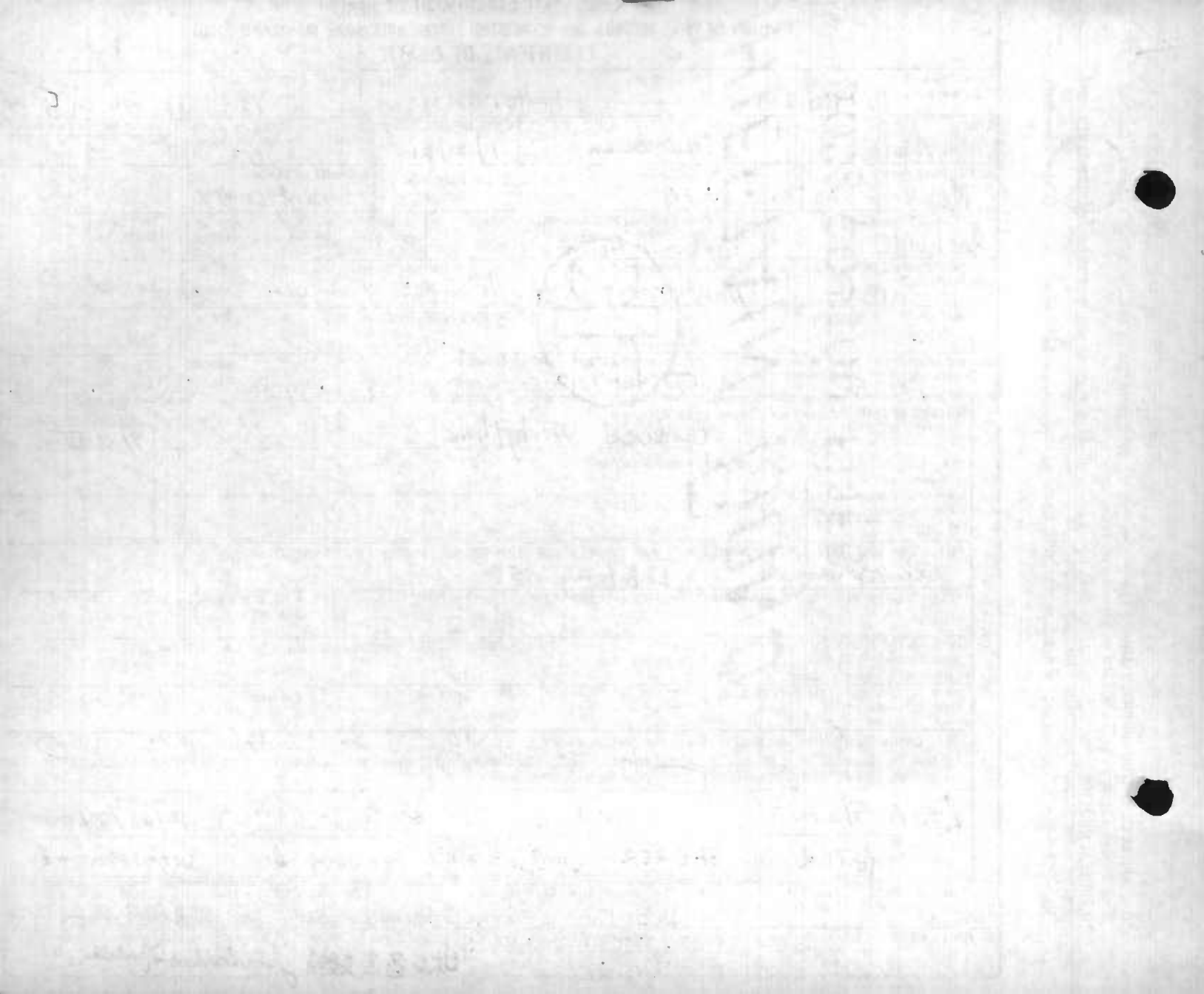
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | |
|--|---|---|---|---|
| 1. DECEASED-NAME
(Type or print) Abraham First Middle Lost Hellerman | | 2a. DATE OF DEATH
Month 12 Day 25 Year 84 | | 2b. HOUR
5:20 PM |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH
1/21/21 | 6. AGE (In years
last birthday)
63 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN |
| 7a. BIRTHPLACE (State or foreign
country)
New York, NY | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH
Rockville | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Hebrew Home | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Unemployed | 12b. KIND OF BUSINESS OR
INDUSTRY
N/A | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before
admission) STATE
md | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Rockville | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
6121 montrose Rd (20852) |
| 14. FATHER'S NAME
First Middle Last
Max Hellerman | 15. MOTHER'S MAIDEN NAME
First Middle Last
Bertha Goldstein | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown No (If yes give war or dates of service) | | |
| 16b. SOCIAL SECURITY NO.
578-44-7213 | | 17. INFORMANT
Address 20901
Sylvia Dier; 827 Malibu Drive; Silver Spring, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrhythmia
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. (b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
Acute | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Schizophrenia Lobotomy 1950 | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10 , 19 84 to 12/25 , 19 84 , that (I) (we) last
saw the deceased alive on 12/25 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
Peter B. Sherer MD | | 22c. DATE SIGNED
12/26/84 | 22d. PHYSICIAN'S
NAME (Type) PETER B SHERER MD | |
| 22e. ADDRESS
3947 Ferrara Dr. Wheaton Md. | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | 23b. DATE
12/27/84 | 23c. NAME OF CEMETERY OR CREMATORY
Beth Shalom Cong. Cemetery | 23d. LOCATION (City or Town) (County) (State)
Capitol Heights; P.G.; Maryland | |
| 24. FUNERAL DIRECTOR
DANZANSKY-GOLDBERG MEMORIAL CHAPELS | | 25a. REC'D BY REGISTRAR
466 31 1884 | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |
| 1170 Rockville Pike; Rockville, Md. 20852 | | | | |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH34012
REG. NO.FOR
1. STATE
REGISTRAR

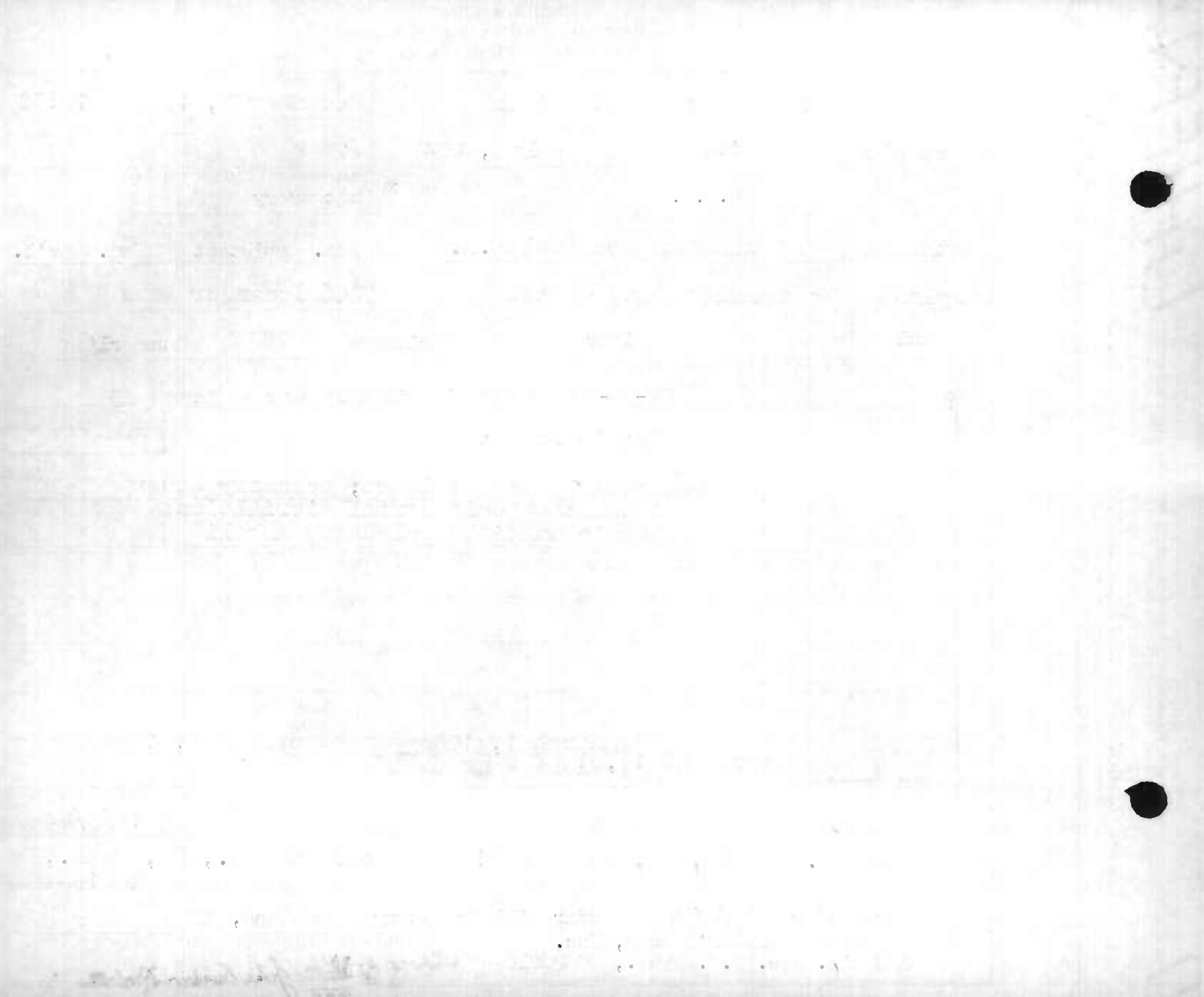
| | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Marion Margaret Hiser | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 5, 1984 | | | 2b. HOUR
10:32 ^A _M | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 8, 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY)
87
YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
DC | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital E.R. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Adm. Assistant | | 12b. KIND OF BUSINESS OR INDUSTRY
Fed. Gov't. | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Chevy Chase | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
7206 Pomander Lane 20815 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Paul Hiser | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Kunigunda Wunderlick | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
579-58-0978 | | 17. INFORMANT
ADDRESS
Carroll Williams Same as item # 13 | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Congestive Heart Failure; Coronary Artery Disease; Chronic Atrial Fibrillation; Chronic multiple pulmonary Emboli
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 1, 1984 to December 5, 1984, that (I) (we) lost
saw the deceased alive on November 12, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
George A. Boinis MD | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/5/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
George A. Boinis, MD, PC | | | | | | 22e. ADDRESS
5410 Connecticut Ave., NW, Wash., DC 20015 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
12/6/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland, MD | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Joseph Gawler's Sons, Inc.
5130 Wis. Ave. N.W. Wash., DC 20016 | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

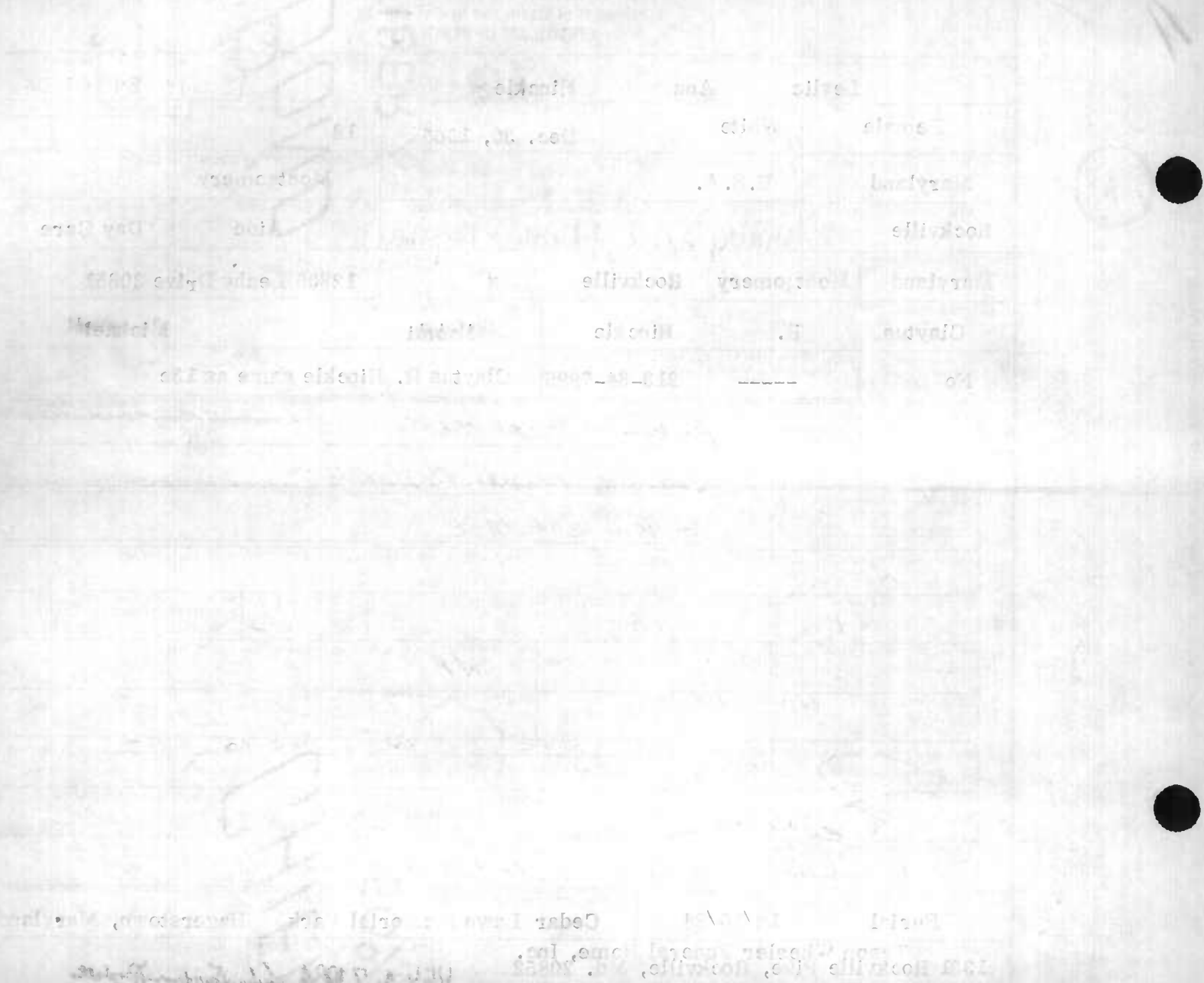


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | REC. NO. 3-4013 | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| Leslie | | Ann | | Hinckle | | | | 12 13 84 0702A.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. UNDER 1 YEAR | |
| Female | | White | | Dec. 30, 1965 | | 18 | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | U.S.A. | | | | Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | |
| Rockville | | Shady Grove Adventist Hospital | | | | | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Aide | | Day Care | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE | |
| Maryland | | Montgomery | | Rockville | | | | 12805 Leahy Drive 20851 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | | | |
| Claytus R. Hinckle | | Naomi Michael | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| No | | 213-84-7999 | | Claytus R. Hinckle same as 13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) PNEUMOCOCCAL SEPSIS | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | | |
| (b) CHRONIC RENAL FAILURE | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) ASPENIC STATE | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NA | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| NA | | NA | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | P.M. 19 | | NA | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| NA | | | | NA | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10:00, 19 84, to DEC 13, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | 22c. DATE SIGNED | | | |
| J.C. WEIDIG | | | | | | 12/13 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| J.C. WEIDIG M.D. | | 14805 PHYSICIAN'S LA, ROCKVILLE, MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | 12/15/84 | | Cedar Lawn Memorial Park | | Hagerstown, Maryland | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | |
| Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852 | | | | | | DEC 17 1984 Julia Davidson | | | |



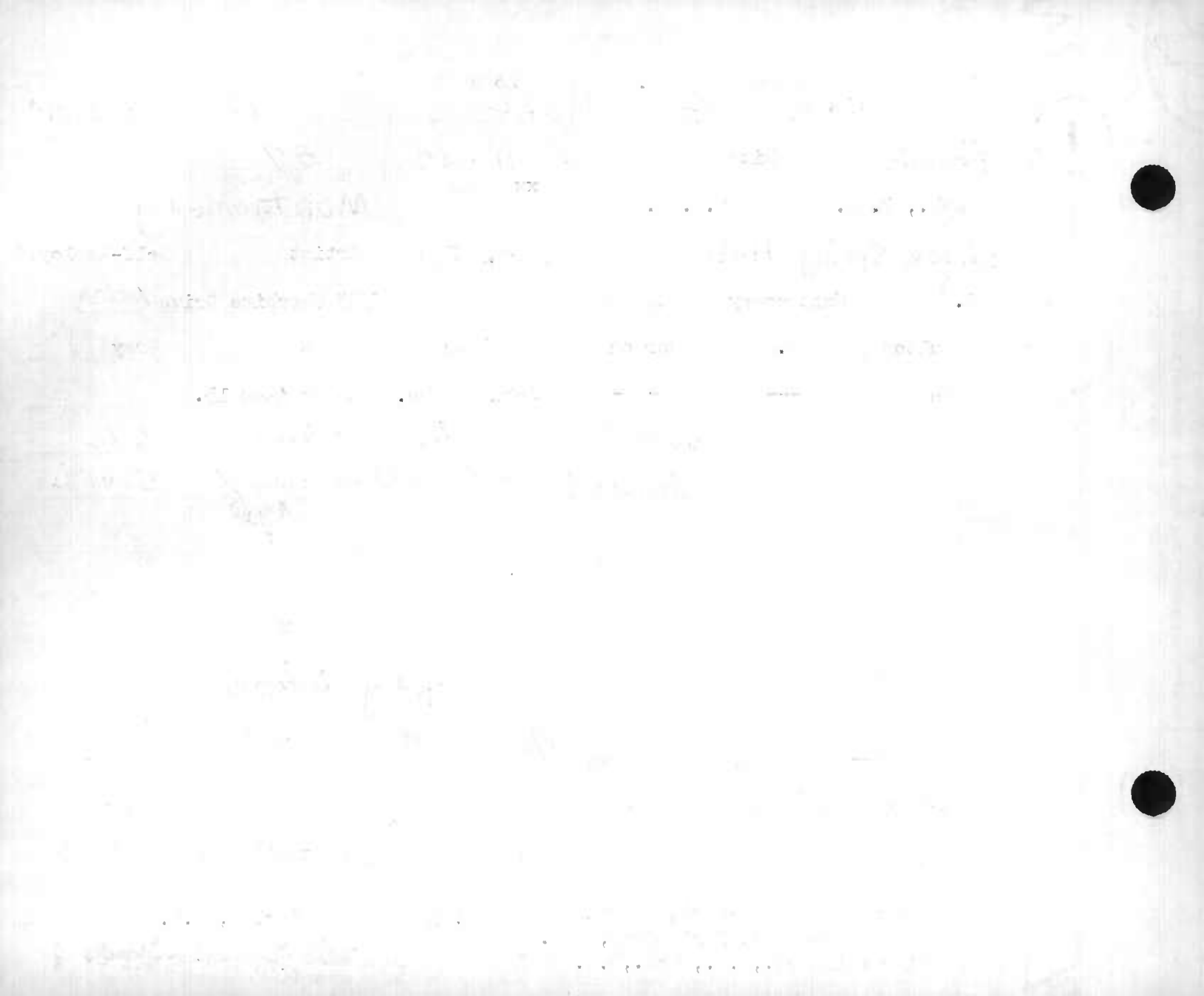
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 34014 | |
|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) June G. Hoke | | | 2a. DATE OF DEATH
MONTH DAY YEAR 12-6-84 | | | 2b. HOUR
3:01A | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR 4-11-27 | | 6. AGE (IN YEARS LAST BIRTHDAY)
57 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash., D. C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
silver spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Artist | | 12b. KIND OF BUSINESS OR INDUSTRY
Self-Employed | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
5933 Cheshire Drive /20814 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Fulton R. Gordon | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ellen M. Gray | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
--- | | 17. INFORMANT
John R Hoke. Same as item 13. | | | | ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) non-cardiogenic pulmonary edema | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 hrs | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) bronchioloalveolar cell carcinoma | | | | | | | | | | 5 months | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
ok'd by Dr. Rogers | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/1 , 19 84 , to 12/6 , 19 84 , that (I) (we) lost
saw the deceased alive on 12/2 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Brue A. Silver, MD | | | | | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/6/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Brue A. Silver | | | | | | 22e. ADDRESS
106 King St, N.W. #421 Wash DC 20010 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
12/10/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Glenwood Cemetery | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D.C. | | | |
| 24. FUNERAL DIRECTOR
NAME Joseph Gawler's Sons, Inc.
ADDRESS 5130 Wisconsin Ave., N.W., Wash., D.C. 20016 | | | | | | 25. DATE REC'D BY REGISTRAR DEC 12 1984
25b. REGISTRAR'S SIGNATURE
J. G. Gawler | | | | | |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REC. NO. 34015 | |
|--|--|--|--|--|--|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | 2a. DATE KNOWN OF DEATH | |
| DECEASED NAME (TYPE OR PRINT) <u>William E. Holmead</u> | | | | | | | | | | MONTH DAY YEAR <u>Dec 8 1984</u> | |
| SEX <u>M</u> RACE <u>W</u> DATE OF BIRTH <u>Nov 20 1907</u> AGE (IN YEARS) <u>77</u> YRS. IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | | 3. DATE PRONOUNCED DEAD <u>Dec 8 1984</u> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>WASHINGTON, D.C.</u> | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD. | |
| 10. CITY OR TOWN OF DEATH <u>Silver Spring</u> | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY <u>LAND SURVEYOR</u> | |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Memorial Hospital</u> | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>LAND SURVEYOR</u> | |
| 13a. STATE <u>MD</u> 13b. COUNTY <u>Mont</u> 13c. CITY OR TOWN <u>Kensington</u> | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <u>10920 Conn. Ave</u> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>WILLIAM E. HOLMEAD</u> | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>MARIE STUBBS</u> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>NO</u> | | | | | | | | | | 16b. SOCIAL SECURITY NO. <u>214-03-9794</u> | |
| 17. INFORMANT ADDRESS <u>ETHEL C. HOLMEAD SAME AS 13 WIFE</u> | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
<u>8880 Pulmonary Embolism</u>
IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u>
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last
(b) <u>Fracture L. hip</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>26 Lys</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>None</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION <u>11-13-84</u> | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <u>FRACTURE LEFT HIP</u> | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u>None</u> | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>11 12 1984</u> | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <u>Fall at home</u> | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <u>None</u> | |
| 21f. LOCATION CITY OR TOWN <u>Conn. Ave. Kensington Mont.</u> COUNTY <u>MD</u> STATE <u>MD</u> | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| ACTUAL SIGNATURE <u>John S. Rogers</u> M.D. TITLE (SPECIFY) <u>DOJ</u> MEDICAL EXAMINER | | | | | | | | | | DATE SIGNED <u>Dec 8 1984</u> | |
| EXAMINER'S NAME (TYPE OR PRINT) <u>JOHN S. ROGERS</u> ADDRESS <u>1919 SEMINARY ROAD, SILVER SPRING, MD.</u> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> | | | | | | | | | | 23b. DATE <u>12/10/84</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY</u> | | | | | | | | | | 23d. LOCATION CITY OR TOWN <u>WASHINGTON, D.C.</u> COUNTY <u></u> STATE <u></u> | |
| 24. FUNERAL DIRECTOR NAME <u>FRANCIS J. COLLINS</u> ADDRESS <u>500 UNIV. BLVD., W. SILVER SPRING, MD. 20901</u> | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR <u>DEC 13 1984</u> 25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u> | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 34016 | |
|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MARY EDNA HOPKINS | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR 12/5/84 | | 2b. HOUR
10:45 P.M. | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR July 17 1909 | | 6. AGE
(IN YEARS LAST BIRTHDAY) 75 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Gaithersburg | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HERMAX Wilson Health Care Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY
Education | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13a. STREET ADDRESS / ZIP CODE | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
103 Russell Ave. #208 20877 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Benjamin Edward Hopkins | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Elizabeth Howes | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO.
214-40-7551 | | 17. INFORMANT
Records 301 Russell Ave. Gaithersburg, Md. 20877 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory failure
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Compression due to Meningioma 1 mo
DUE TO, OR AS A CONSEQUENCE OF (c) —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 min | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:
— | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from Nov 28 , 19 84 , to Dec 5 , 19 84 , that (1) (we) last saw the deceased alive on Dec 3 , 19 84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
James R. Moore Jr. | | | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12-6-84 | |
| 22d. PHYSICIAN'S NAME (PRINT) | | | | | | 22e. ADDRESS
207 Brookes Ave Gaithersburg Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Cremation | | | | 23b. DATE
12/6/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Lee's Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D.C. | | | |
| 24. FUNERAL DIRECTOR
NAME
Gartner Sandison F.H. | | | | | | 316 E. Diamond Ave. Gaithersburg, Md. 20877 | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
DEC 13 1984 Gartner Sandison F.H. | | | |

BP _____



Corporate Computer, also to the computer 1 mo

James R. Moore, Jr.
202 E. 1st St. N.W.
Washington, D.C.
15-8-81

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 34017

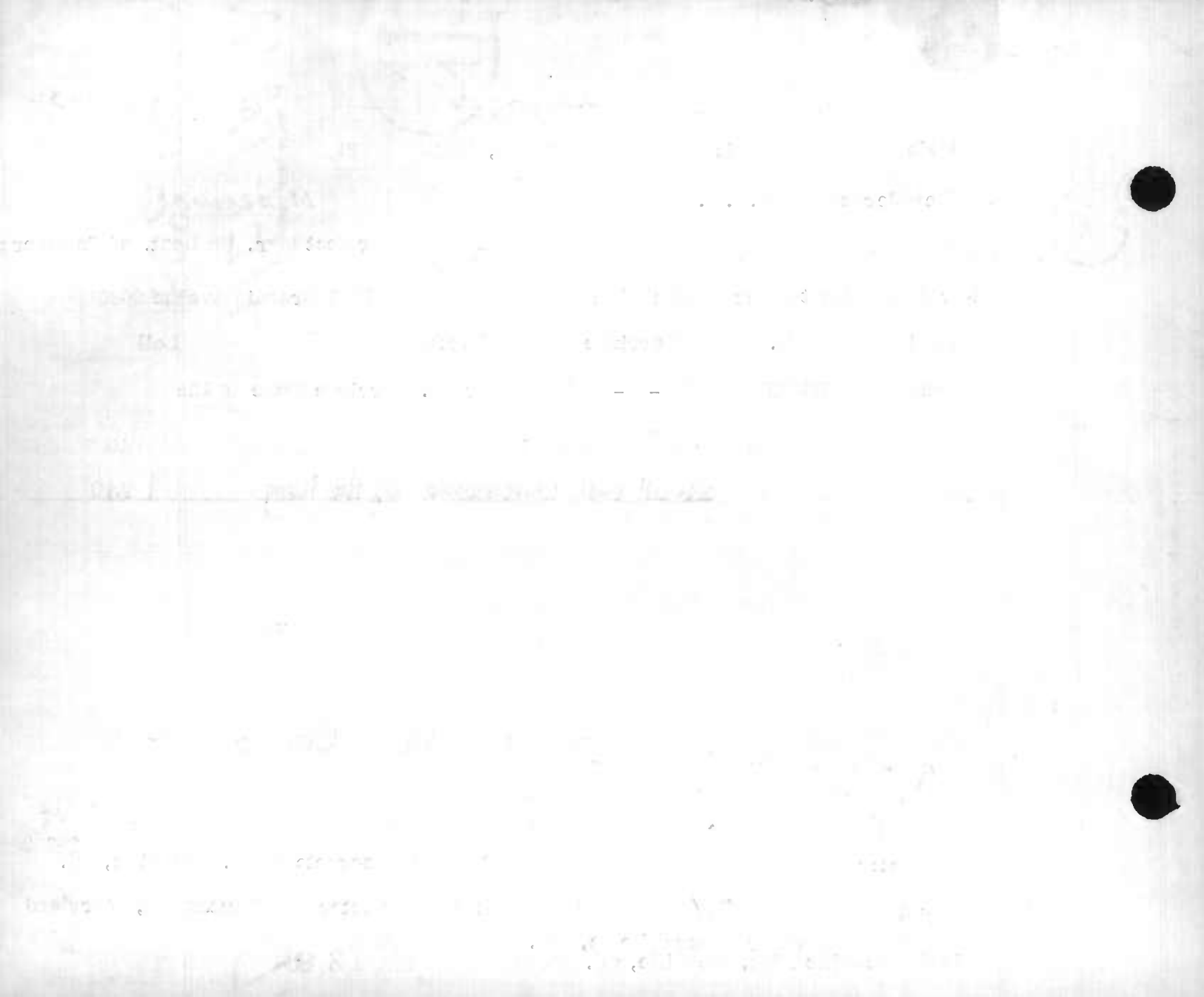
| | | | | | |
|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
DAVID L. HORRIDGE | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 6 84 | | 2b. HOUR
12 55 PM | |
| 3. SEX
Male | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 20, 1923 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
61 | | 7a. BIRTHPLACE
(STATE OR FOREIGN)
New Jersey | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SUBURBAN HOSPITAL | | 12a. USUAL OCCUPATION
Project Mgr. US Dept. of Commerce | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | |
| 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1301 Grandin Avenue 20851 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
David L. Horridge | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bertha Loll | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
(IF NOT IN U.S. ARMY OR NAVY)
WW II 146-16-5641 | | 17. INFORMANT
ADDRESS
Laura H. Horridge same as 13e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis
DUE TO, OR AS A CONSEQUENCE OF
(b) small cell carcinoma of the lung
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 mo
9 mo | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Apr. 1 1984 to Dec 6 1984, that (I) (we) last saw the deceased alive on Dec 6 1984 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Peter Pushkas | | 22c. DATE SIGNED
12/7/84 | | 22d. ADDRESS
11510 Old Georgetown Rd. Rockville, Md. 20852 | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE OR PRINT)
Burial | | 23b. DATE
12/10/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Maryland Veterans Cemetery | |
| 23d. LOCATION
(CITY OR TOWN)
Cheltenham, Maryland | | | | | |
| 24. FUNERAL DIRECTOR
Tyson Wheeler Funeral Home, Inc.
1331 Rockville Pike, Rockville, Md. 20852 | | 25. DATE REC'D. BY REGISTRAR
DEC 12 1984 | | | |
| 25. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Med Examining Notified & Replied

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH34018
REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR
STATE
REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
NORMAN G. HOUGH JR. | | 2a. DATE OF DEATH MONTH DAY YEAR
December 21, 1984 | | 2b. HOUR
9:30A.M. | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 25 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Penna. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Sales Agent | | 12b. KIND OF BUSINESS OR INDUSTRY
Real Estate | |
| 13a. STATE
Md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Chevy Chase | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Norman G. Hough, Sr. | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Olive Gilmore | | 13e. STREET ADDRESS / ZIP CODE
7207 Maple Ave. 20815 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII | | 17. INFORMANT
Vera K. Hough. Same as item 13. | | ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLUS</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
<u>DIABETES MELLITUS, PERIPHERAL VASCULAR DISEASE LEGS</u> | | | | | | | |
| 19a. DATE OF OPERATION
11-17-84 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Amputation Right Leg - GANGRENE FOOT | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 <u>68</u> to <u>12/21</u> 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>12/14</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Edwin P. Parker III M.D. | | | | DEGREE
M.D. | | 22c. DATE SIGNED
12/21/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Edwin P. Parker III M.D. | | | | 22e. ADDRESS
2015 R st. N.W. Washington D.C. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/24/1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Quantico National Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Quantico, Virginia | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Joseph Gawler's Sons Inc.
5130 Wisc. Ave., N.W. Wash., D.C. | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
DEC 28 1984 | |

X

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| 1- STATE REGISTRAR | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 34019 | | | |
|--|--|---|--|---|--|--|--|---|--|--|--|---|--|------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)
Charles W. HOUSTON | | | | | | | | | | | | 2a. DATE KNOWN OF DEATH
Dec. 24 1984 | | 2b. HOUR
8:50 P. M. | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
Mar. 31, 1926 | | 6. AGE (IN YEARS)
58 YRS. | | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | | 7c. DATE PRONOUNCED DEAD
Dec. 24, 1984 | | 7d. HOUR
8:50 P. M. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Damascus | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
12011 Bethesda Church Rd. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Electrical Contractor | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Damascus | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
12011 Bethesda Church Rd. 20872 | | | | | |
| 14. FATHER'S NAME
Charles C. Houston | | | | 15. MOTHER'S MAIDEN NAME
Vivian Scott | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes | | | | 16b. SOCIAL SECURITY NO.
WW2 225-26-0590 | | | | 17. INFORMANT ADDRESS
Dorothy P. Houston, Item 13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Metastatic carcinoma</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last.
(b) <u>carcinoma of the bladder.</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 yrs. | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
None | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
October 28, 1984 | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
Carcinoma of the bladder. | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
None | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>John S. Rogers</i> | | | | TITLE (SPECIFY)
Deputy | | | | MEDICAL EXAMINER
1919 Seminary Road | | | | DATE SIGNED
12/24/84 | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
John S. Rogers, M.D. | | | | ADDRESS
Silver Spring, Montgomery, Md. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
Dec. 28, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville, Montgomery, Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Olin L. Molesworth, P.A., Damascus, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 31 1984 | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Rodgers</i> | | | | | | | |

Metastatic carcinomas

carcinoma of the bladder.

None

Carcinoma of the bladder.

None

X

X

1919 Seminary Road
Silver Spring, Montgomery, Md.

John S. Rogers, M.D.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH34020
REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. FOR
STATE
REGISTRAR | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 11 26 84 | | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Male | | Black | | MONTH DAY YEAR | | 83 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Maryland | | U.S. | | | | Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Silver Spring | | Holy Cross Hosp. | | Farmer | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. STREET ADDRESS | |
| Md. | | Mtg. | | Kensington | | 10231 Carrol Place 20895 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| Joseph | | Nancy | | No | | 220-10-5767 | |
| 17. INFORMANT | | ADDRESS | | 17. INFORMANT | | ADDRESS | |
| Ms. Alma Dorsey | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) | | Ventricular fibrillation | | instant | |
| (c) | | DUE TO, OR AS A CONSEQUENCE OF | | Coronary heart disease | | years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | cerebrovascular insufficiency | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 12/26, 1983, to 11/26, 1984, that (1) (we) saw the deceased alive on 11/26, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
Martin C. Sharkey M.D. | | 22c. DATE SIGNED
11/26/84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 22f. DATE REC'D. BY REGISTRAR | | 22g. REGISTRAR'S SIGNATURE | |
| MARTIN C. SHARKEY M.D. | | 3720 FARFAIR AVE
KENSINGTON MD 20895 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| Removal | | 12/14/84 | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Anatomy Board | | Balto., Md. | | DEC 19 1984 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED
FEB 10 1964



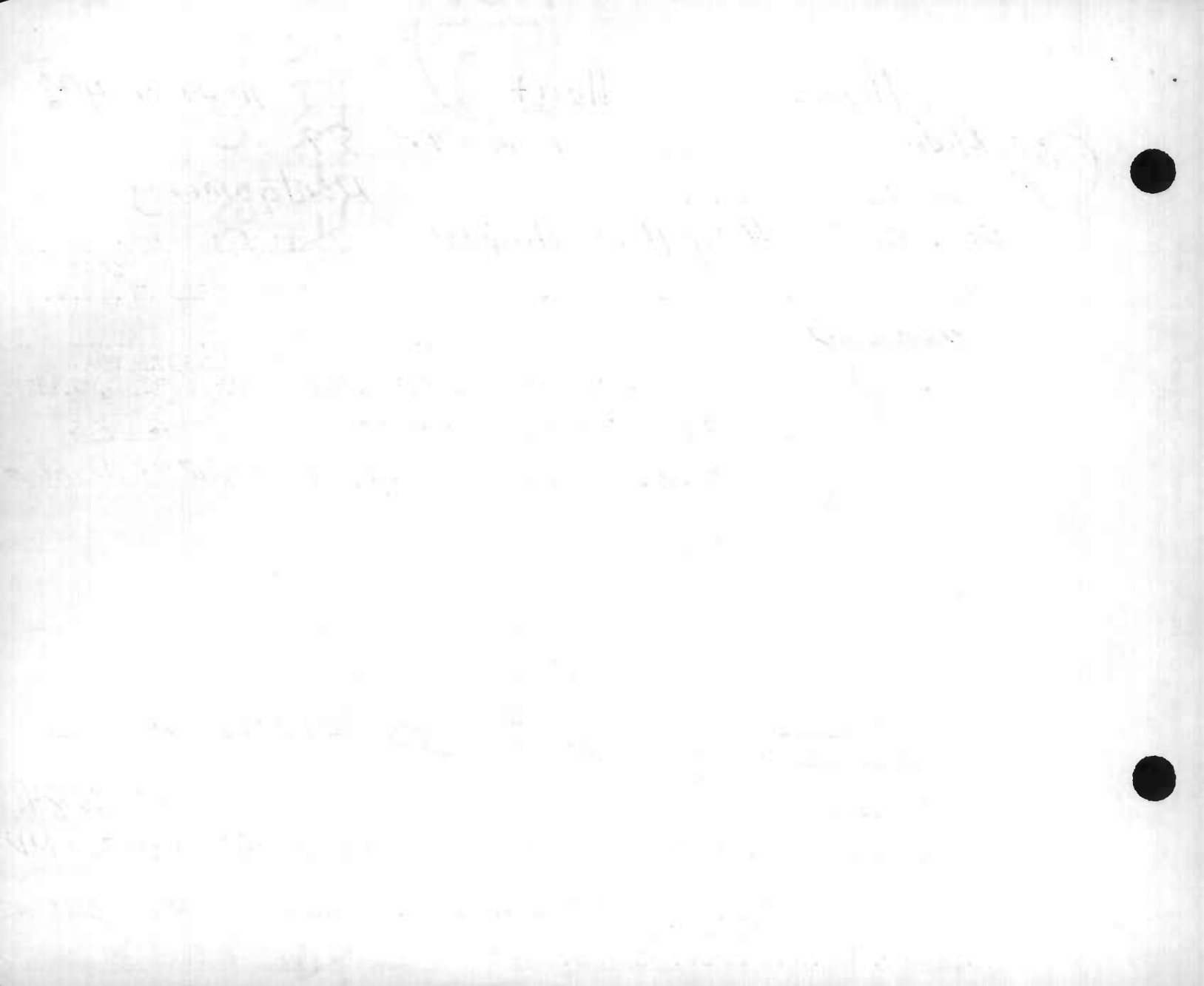
DEC 10 1963

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 34021 | |
|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Homeer Hoyt | | | | 2a. DATE OF DEATH MONTH DAY YEAR
11-29-84 2b. HOUR
4:20 AM | |
| 3. SEX
Male | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR
6-14-95 | |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MISSOURI | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.
89 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MISSOURI | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF ACT IN SUCH FACILITY, CITY STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
CONSULTANT | |
| 13a. STATE
N/A | | 13b. COUNTY
N/A | | 13c. CITY OR TOWN
WASHINGTON | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Unknown | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
E. M. VATH | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
578-54-4306 | | 17. INFORMANT
SON | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) aspiration pneumonia
DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic cerebrovascular disease
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 wks | | 12b. KIND OF BUSINESS OR INDUSTRY
SELF EMPLOYE | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from 28 NOV 1984 to 29 NOV 1984 , that (I) (we) last saw the deceased alive on 28 NOV 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE DEGREE
Walter E. Goetz MD | | | | 22c. DATE SIGNED
29 NOV 84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
WALTER E. GOETZ MD | | | | 22e. ADDRESS
2309 SHOREFIELD RD WHEATON MD | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
12/4/84 | | 23c. NAME OF CEMETERY OR CREMATORY
HOLY SCEPULCHRE CEM. | |
| 23d. LOCATION CITY OR TOWN
CHICAGO | | 23e. COUNTY
COOK | | 23f. STATE
ILLINOIS | |
| 24. FUNERAL DIRECTOR NAME
FRANCIS J. COLLINS | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 6 1984 | |
| 25b. REGISTRAR'S SIGNATURE
Davidson | | | | 25c. ADDRESS
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 34022 | |
|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Chung Y. HSIAO | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-18-84 | | 2b. HOUR
12:26 AM |
| 3. SEX
M MALE | 4. RACE
O ORIENTAL | 5. DATE OF BIRTH
MONTH DAY YEAR
3-12-00 | 6. AGE
(IN YEARS LAST BIRTHDAY)
84 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
CHINA | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CIVIL ENGINEER | | 12b. KIND OF BUSINESS OR INDUSTRY
CHINESE GOVT. |
| 13a. STATE
MARYLAND | 13b. COUNTY
MONTGOMERY | 13c. CITY OR TOWN
SILVER SPRING | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
806 DALEVIEW DRIVE 20901 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
kwei HSIAO | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SIV-CHEN YANG | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
577-58-7816 | | 17. INFORMANT
ADDRESS
HELEN YAO HSIAO, WIFE, SAME AS ITEM #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Adenocarcinoma of the lungs, Stage III | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
8 mos |
| DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | (b) _____
(c) _____ |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 12-13 1984 , to Dec 1984 , that (I) (we) lost saw the deceased alive on 12-13 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Kai-Yin Yeung, MD | | DEGREE
MD | | 22c. DATE SIGNED
12-18-84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Kai-Yin Yeung, MD | | 22e. ADDRESS
8926 Woodyard Rd #201 Clinton, MD 20735 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12/22/84 | 23c. NAME OF CEMETERY OR CREMATORY
ROCK CREEK CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
WASHINGTON, D.C. |
| 24. FUNERAL DIRECTOR
NAME
RICHARD RAPP INC WASHINGTON, D.C. 20009 | | 1804 T ST., N.W.
ADDRESS | | 25a. DATE REC'D. BY REGISTRAR
DEC 26 1984 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be conducted.

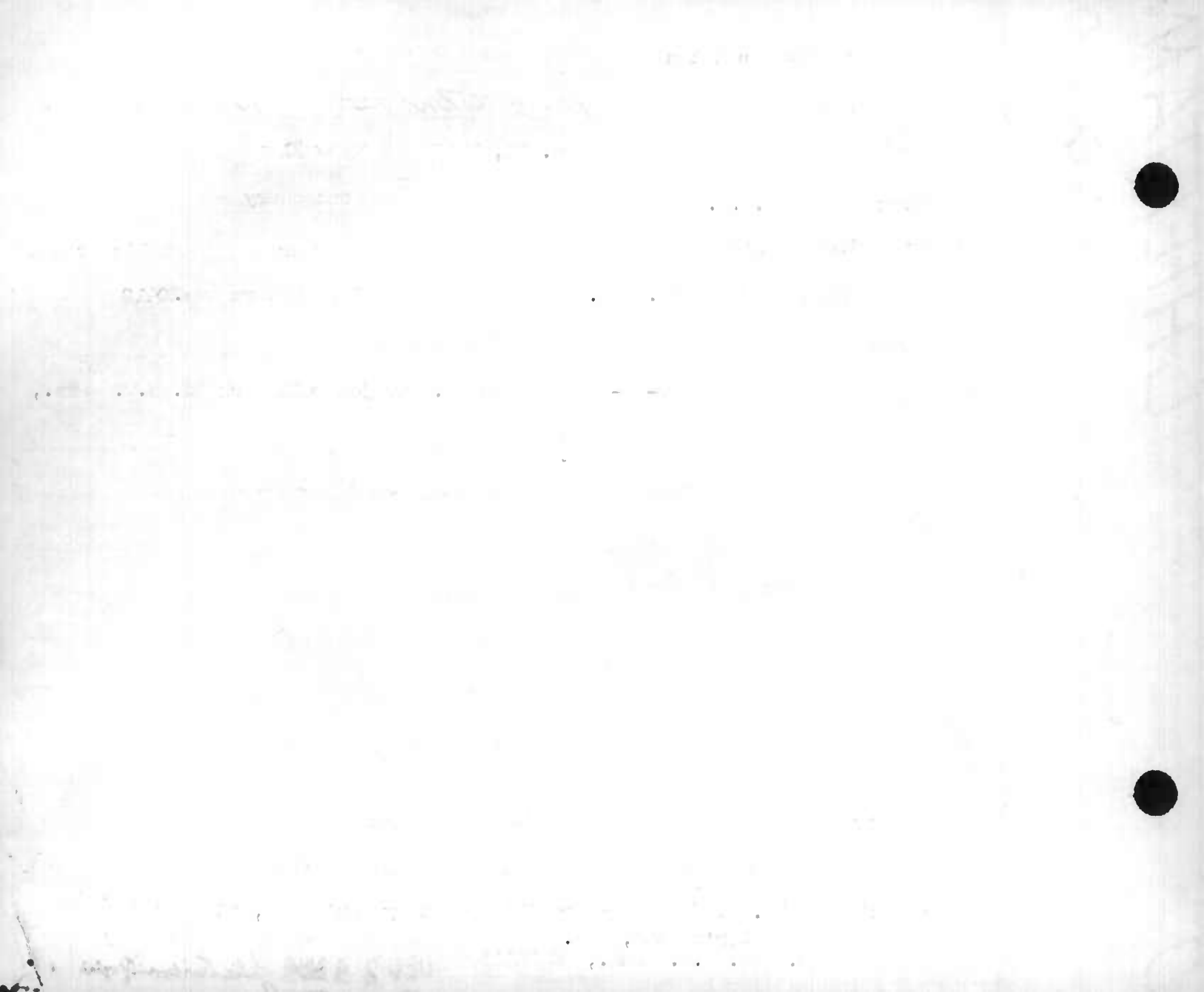
BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 34023

1. FOR STATE REGISTRAR Ora Etta Hughston

| | | | | | |
|---|--|--|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
OKA E HUGHSTON | | | 2a. DATE OF DEATH MONTH DAY YEAR
12/15/84 | | 2b. HOUR
2:23 PM |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH MONTH DAY YEAR
Jan. 21, 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS
81 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Unknown | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY
Public Schools |
| 13a. STATE
MD | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Sil. Spg. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Unknown | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
577-64-5856 | | 17. INFORMANT ADDRESS
Edward A. Tirajoh 2011 Park Rd. N.W. Wash., DC | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>End stage Ischemic Heart Disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Renal Failure</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 25, 1984</u> to <u>12-15, 1984</u> , that (I) (we) last saw the deceased alive on <u>12-15, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Steven A. Burger</u> MD | | DEGREE | | 22c. DATE SIGNED
12-16-84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Steven A. Burger, MD | | 22e. ADDRESS
2101 Medical Park Dr. Silver Spring, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
12/17/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE
Suitland, MD | | 23e. DATE REC'D. BY REGISTRAR | | | |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.
NAME 5130 Wisc. Ave. N.W. Wash., DC 20016 | | 25a. DATE REC'D. BY REGISTRAR
DEC 24 1984 | | | |
| 25b. REGISTRAR'S SIGNATURE
<u>John T. ...</u> | | | | | |



STATE OF MARYLAND

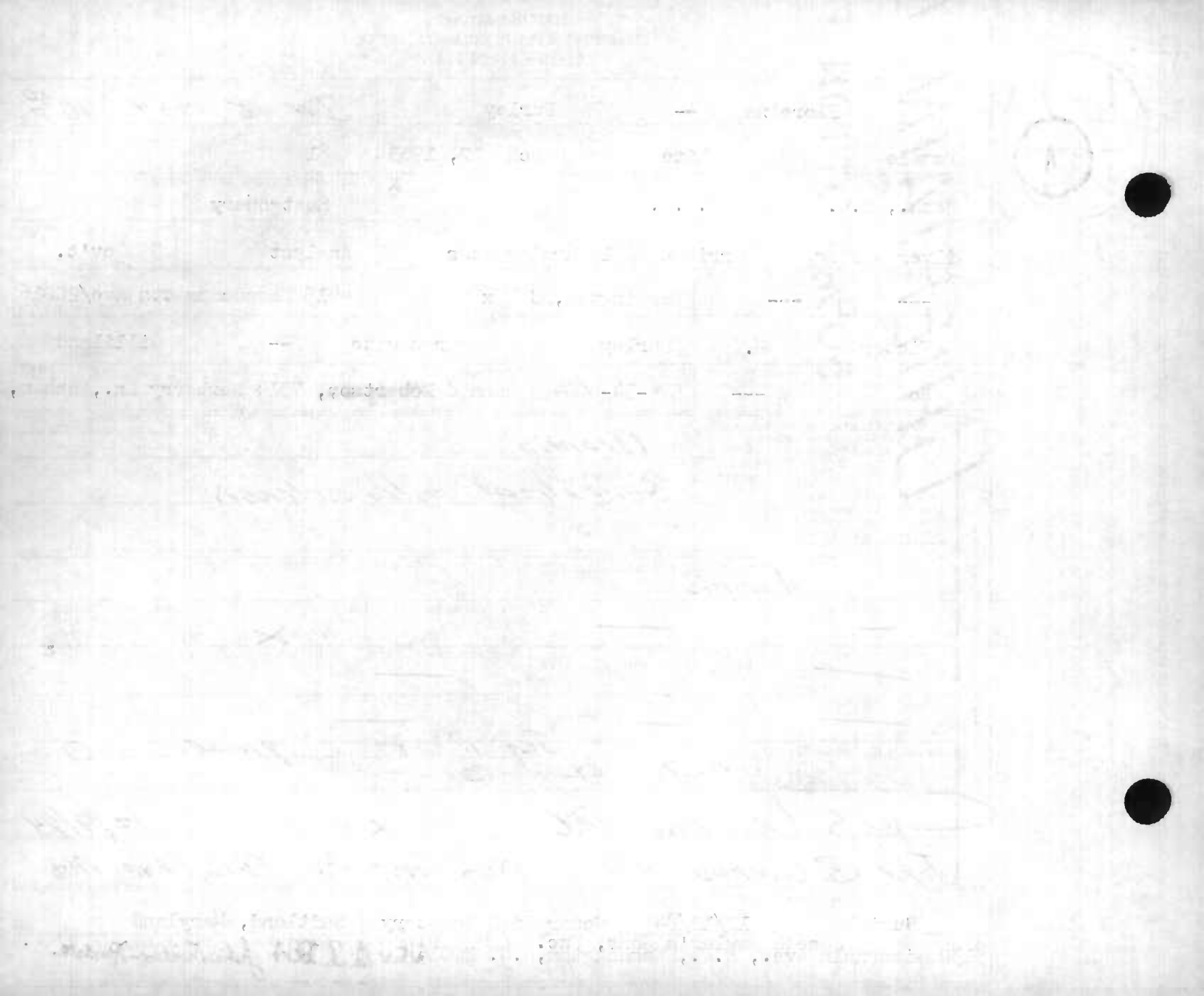
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 4 0 2 4
REG. NO.1 - FOR
STATE
REGISTRAR

| | | | | | | |
|--|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Floréine --- Hurley | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Dec. 8, 1984 | | 2b. HOUR
MIN.
10³⁰ PM | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
March 27, 1903 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
81 | | 7. IF UNDER 1 YEAR
MONTHS DAYS
YRS. | | 8. IF UNDER 24 HRS.
HOURS MIN. | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash., D.C. | | 10. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 12. CITY OR TOWN OF DEATH
Silver Spring | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Carriage Hill Nursing Home | | 14. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
15a. STATE
15b. COUNTY
Washington, D.C. | | 16. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 17. STREET ADDRESS
4915 Massachusetts Ave/20016 | | |
| 18. FATHER'S NAME
FIRST MIDDLE LAST
Victor M. Hurley | | 19. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Marguerite --- Gilliland | | 20. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Analyst | | |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 22. SOCIAL SECURITY NO.
579-34-4004 | | 23. INFORMANT
ADDRESS
Donald Robertson, 7514 Newberry Ln., Lanham, MD | | |
| 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c) _____
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Anemia | | | | | | |
| 25a. DATE OF OPERATION
--- | | 25b. CONDITION FOR WHICH OPERATION WAS PERFORMED
--- | | 26a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 27a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 27b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
--- | | |
| 28a. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | | 28b. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
--- | | 28c. LOCATION
STREET CITY OR TOWN COUNTY STATE
--- | | |
| 29. I certify that (I) (this hospital) attended the deceased from July 11, 1983 to present , that (I) (we) lost saw the deceased alive on Dec. 7, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | |
| 30. SIGNATURE
D.S. Umbrico MD | | 31. DEGREE
MD | | 32. DATE SIGNED
12/19/84 | | |
| 33. PHYSICIAN'S NAME (TYPE OR PRINT)
John B. Umbrico MD | | 34. ADDRESS
8805 Conn. Ave., Chevy Chase MD | | | | |
| 35a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 35b. DATE
12/12/84 | | 35c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | |
| 35d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland, Maryland | | 36. DATE RECEIVED BY POSTAL SERVICE
DEC 17 1984 | | | | |
| 37. FUNERAL DIRECTOR
Joseph Gawler's Sons, Inc. | | 38. ADDRESS
5130 Wisconsin Ave., N.W., Washington, D.C. 20017 | | 39. REGISTRAR'S SIGNATURE
Jana Davidson | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 22 shows any injury, or other traumatic event, the medical examiner should be notified at once.



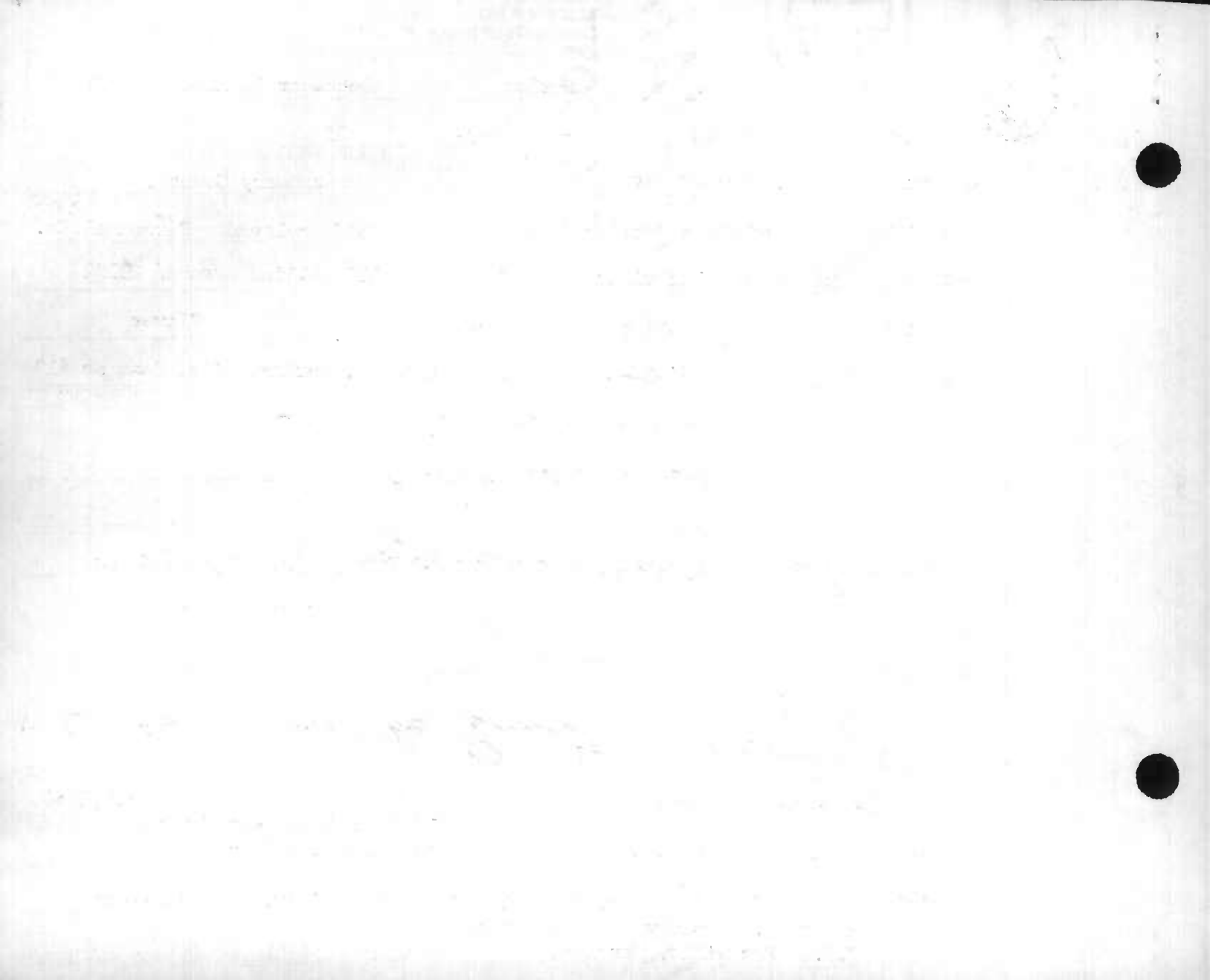
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card-indexers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

| 1- STATE REGISTRAR | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE
STATE OF MARYLAND
CERTIFICATE OF DEATH | | | | 34025
REG. NO. | | | |
|---|--|---|--|---|---|---|--|--|---------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
James G. Hurley | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 1, 1984 | | | | 2b. HOUR
5:00P M |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 24, 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Rockville Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Self Employed | | 12b. KIND OF BUSINESS OR INDUSTRY
Personnel Co. | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
199 Rollins Avenue/ 20852 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Daniel Hurley | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Plover | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
084-14-6984 | | 17. INFORMANT ADDRESS
Mrs. Katherine R. Hurley, Wife, Same as #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) <u>Carcinoma of Lung</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:
<u>Pulmonary Fibrosis, Long-term Starvation, Renal Failure</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 10, 1984</u> to <u>12/1, 1984</u> , that (I) (we) last saw the deceased alive on <u>12/1, 1984</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>D. Shumaker, M.D.</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
Dec. 1, 1984 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Douglas R. Shumaker, M.D. | | | | 22e. ADDRESS
615 West Montgomery Avenue
Rockville, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
December 5, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Wollaston Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Quincy, Massachusetts | | | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey Funeral Homes,
P.A., Rockville, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 5 1984 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Swisher-Randall</u> | | | |

BP _____



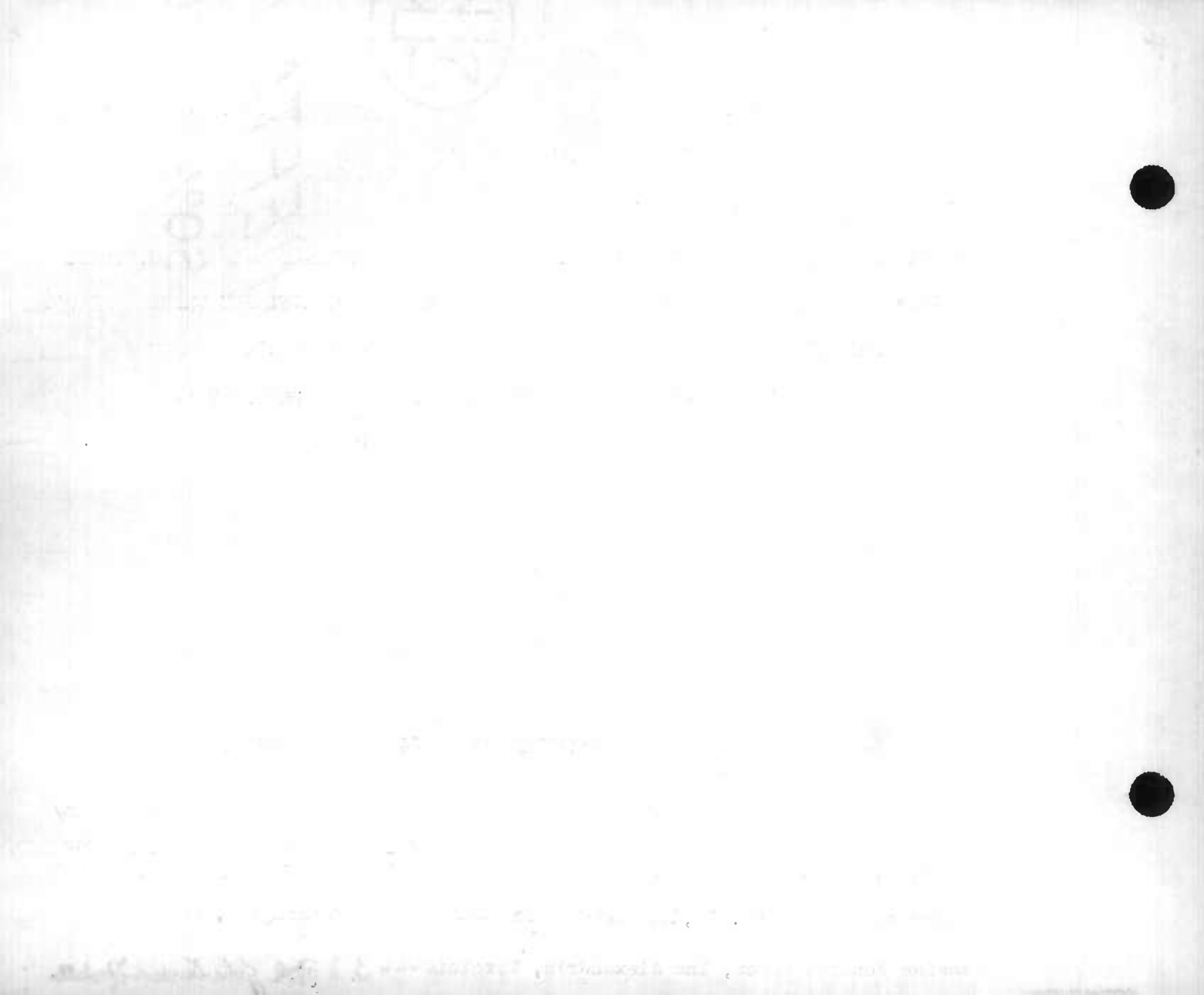
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified. (See page 1 of the Medical Certification form.)

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 3 4 0 2 6
REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| JOHN HUSON | | | | | | | | DECEMBER 20 1984 | | 11:19 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| MALE | | CAUCASIAN | | JUNE 15 1917 | | 67 YRS | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| HOLLAND | | UNITED STATES | | | | MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| BETHESDA | | NAVAL HOSPITAL | | | | RETIRED | | U.S. NAVY | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE | | | |
| VIRGINIA | | FAIRFAX | | ANNANDALE | | | | 4604 MONTEREY DRIVE 22003 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| JOHN HUSON | | | | CAROLINE FREDERICKA DEJONGE | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | ADDRESS | | | | | |
| YES | | 1938-1969 | | 128-22-2935 | | PHYLISS HUSON, 4604 MONTEREY DRIVE | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) SQUAMOUS CELL CARCINOMA OF THE LUNG | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 17 19 84, to DECEMBER 20 19 84, that (I) (we) lost saw the deceased alive on DECEMBER 20 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE DEGREE | | | | | | 22c. DATE SIGNED | | | | | |
| Richard L. Nemecek MD | | | | | | 22d. ADDRESS | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | | | |
| R. L. NEMEC, LT, MC, USNR | | | | | | NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Cremation | | Dec. 23, 1984 | | Lee's Crematory | | Washington, DC | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Demaine Funeral Homes, Inc Alexandria, Virginia | | | | | | DEC 31 1984 | | John L. Nemecek | | | |



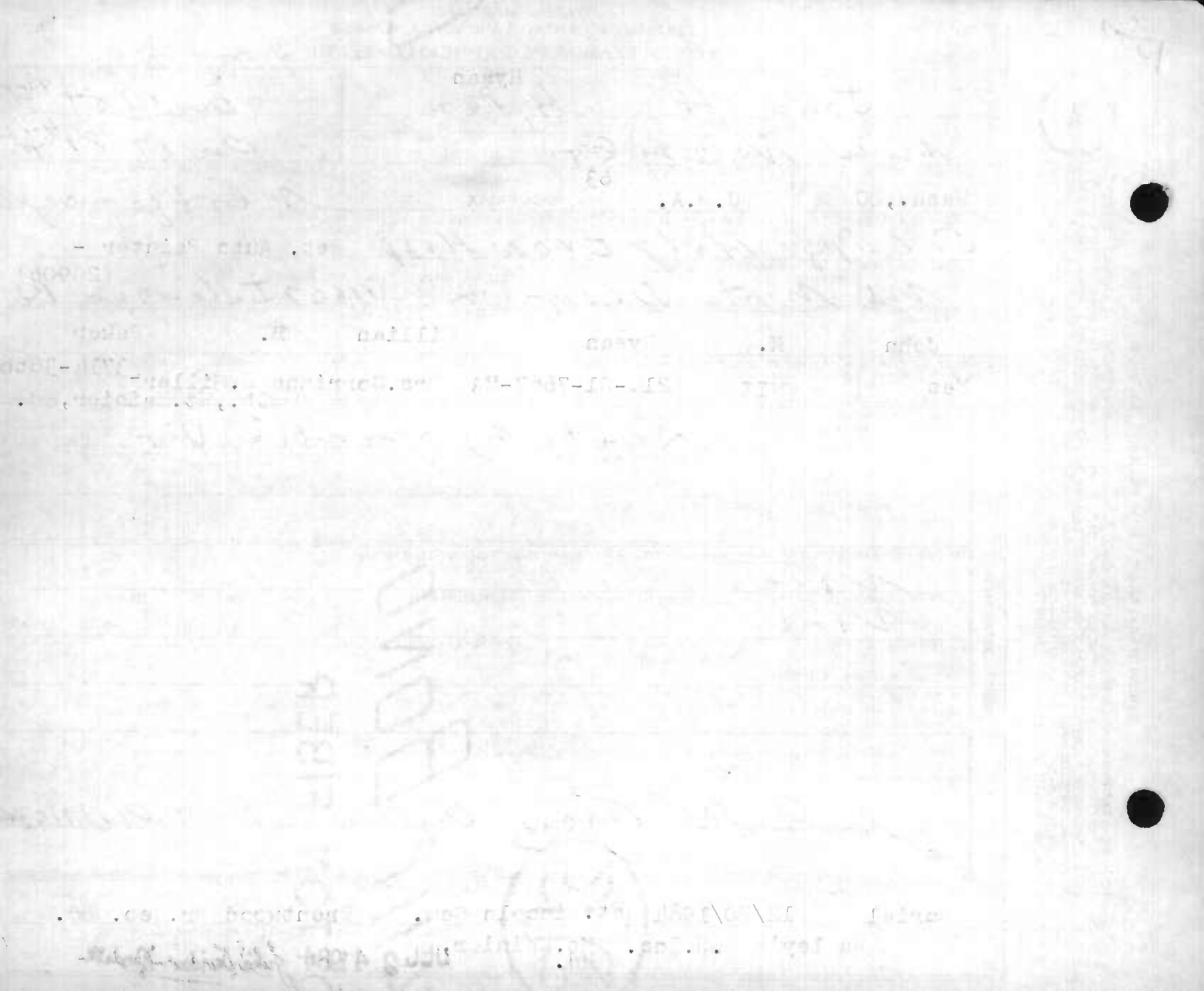
BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
|--|---------------------|---|--|---|------------------|---|--|---|--|
| 1- REGISTRAR | | | | | | REC NO. 34027 | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) John H Hysan | | | | | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR Dec 17 1984 | | 2b. HOUR
MIN 4:45 PM | |
| 3. SEX
M | 4. RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR Nov 22 1932 | 6. AGE (IN YEARS)
LAST BIRTHDAY 53 | 7. UNDER 1 YR.
MONTHS DAYS HOURS MIN | 8. UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR Dec 17 1984 | | 2d. HOUR
MIN 4:45 PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash., DC | | 7b. CITIZEN OF WHAT COUNTRY
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> EVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION)
4517 Evans Hwy | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Auto Painter - | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | 13b. COUNTY
Mont | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
11607 Idlewood Rd (20906) | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John M. Hysan | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lillian B. Baker | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII | | 17. INFORMANT
Mrs. Corrinne E. Miller | | ADDRESS
3714-36th St., Mt. Rainier, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):
None | | | | | | | | | |
| 19a. DATE OF OPERATION
None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE
John H. Hysan | | | | TITLE (SPECIFY)
M.D. | | MEDICAL EXAMINER | | DATE SIGNED
Dec 17 1984 | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | | | ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/20/1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood Pr. Geo. Md. | | | |
| 24. FUNERAL DIRECTOR NAME
Nalley's F.H. Inc. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 24 1984 | | 25b. REGISTRAR'S SIGNATURE
John Hysan | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 12 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 34028 | | | |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST | | | | 2b. HOUR | | | |
| Philip W. Jackson JR | | | | 12/11/84 123 AM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Male | | WHITE | | MARCH 24 1922 | | 62 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| VIRGINIA | | U.S.A. | | | | Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| TAKOMA PARK | | WASHINGTON ADVENTIST HOSPITAL | | AERO ENGINEER | | AERO SPACE | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS / ZIP CODE | |
| MD. CO. GEO | | ADELPHI | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 2512 CHEROKEE ST 20783 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| PHILIP W. JACKSON | | EDITH VALENTINE | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| YES | | W.W. II | | MARQUERITE M. JACKSON - 2512 CHEROKEE ST. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) MULTIPLE CEREBROVASCULAR ACCIDENTS | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | |
| CORONARY ARTERY DISEASE | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from 12-5, 1984, to 12-10, 1984, that (b) (we) lost saw the deceased alive on 12-10, 1984, and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above. (d) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | |
| Pamela Mulshine | | | | MD | | 12-11-84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| PAMELA MULSHINE | | | | 10500 SUMMIT AVE KENSINGTON. MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| CREMATION | | DEC. 12 1984 | | FORD LINCOLN CREMATORY | | Brentwood (P) MD | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 25. DATE DEC'D BY REG. BIRTH REGISTRAR SIGNATURE | | | |
| TAKOMA FUNERAL HOME, J.A. Miller | | 257 CALVERT ST NW | | DEC 13 1984 | | | |

BP

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

34029

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|---|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ADA | | FIRST Lee | | MIDDLE James | | LAST | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-25-84
12 25 84 | | 2b. HOUR OF DAY
4:30 PM
4 30 PM | |
| 3 SEX
FEMALE | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 16 91 | | 6 AGE (IN YEARS LAST BIRTHDAY)
93
YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ohio | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Colonial Villa Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN
Wash., D.C. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
23 Crittenden St., NE. | | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
James Waid Baldridge | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna Mary Alexander | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
579-60-4109 | | 17 INFORMANT (Son) 20601 ADDRESS Waldorf, Md.
Mr. Paul M. James, 2005 Darnell Ct. | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).
Gastrointestinal bleeding | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from 6/9 , 19 81 , to 12/25 , 19 84 , that (I) (we) lost saw the deceased alive on 12/25 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
David C. Lanier, MD | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/26/84 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
David C. Lanier, MD | | 22e. ADDRESS
7676 New Hampshire #210, Park, MD | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12-28-84 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington Nat'l | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington, Arlington, Va. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Huntt Funeral Home, Waldorf, Maryland | | 25a. DATE REC'D. BY REGISTRAR
DEC 27 1984 | | 25b. REGISTRAR'S SIGNATURE
David C. Lanier | | | | | | | |

MEDICAL CERTIFICATION

10-22-57

10-22-57

10-22-57

10-22-57

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10-22-57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|---|---|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
Lottie Jones Jenkins | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 / 29/84 | | | 2b. HOUR
10:40A M | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Nov. 17, 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY)
95 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
USA. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Registered Nurse | | 12b. KIND OF BUSINESS OR INDUSTRY
Nursing | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
14602 Nadine Drive 20853 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Peter D. Jones | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sarah Dorsey | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
237 22 2123 | | 17. INFORMANT
ADDRESS
Lula Peck, 14602 Nadine Drive, Rockville, MD, | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiogenic shock</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe arteriosclerotic Heart Disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Atrial Arrhythmia</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-28-84 to 12-29-84, that (we) last saw the deceased alive on 12-29-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Monique</u> | | | | DEGREE
MD | | | | 22c. DATE SIGNED
12/29/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
B B Monique, MD | | | | 22e. ADDRESS
17904 Georgia Ave Olney MD 20882 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Jan. 1, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Hillside Mem'l Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Laurinburg, North Carolina | | | |
| 24. FUNERAL DIRECTOR
NAME
Ives-Pearson F. Homes, Arlington, Virginia | | | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR
8/18/85 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Rodriguez | |

BP



2020 COLLECTION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 4 0 3 1
REG. NO.1- FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ANNETTE C. JOHNSON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 22, 1984 | | 2b. HOUR
11 P M |
| 3. SEX
FEMALE | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH DAY YEAR
JULY 9, 1921 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
WASHINGTON, D.C. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
13205 BETTY LANE | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SECRETARY | 12b. KIND OF BUSINESS OR INDUSTRY
LEGAL | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
MONTGOMERY | 13c. CITY OR TOWN
SILVER SPRING | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
EDWARD S. JOHNSON | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ALBERTA C. HALL | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
218-16-0689 | | 17. INFORMANT
BROTHER
EDWARD P. JOHNSON
ADDRESS
13205 BETTY LANE
SILVER SPRING, MD. 20904 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory suppression</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Fluid & electrolyte imbalances</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Massive spread of carcinoma at least 9 mo.</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>minutes</u>
<u>2 wks.</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> 19 <u>84</u> to <u>12/22</u> 19 <u>84</u> , that (I) (we) lost above, the deceased alive on <u>12/22</u> 19 <u>84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Richard DeLaney</u> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/24/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RICHARD DELANEY | | 22e. ADDRESS
SILVER SPRING, MARYLAND | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
12/26/84 | 23c. NAME OF CEMETERY OR CREMATORY
OLD ST. JOHNS | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
FOREST GLEN MONT MD. | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS | | ADDRESS
100 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | 25a. DATE REC'D. BY REGISTRAR
DEC 31 1984 | |
| 25b. REGISTRAR'S SIGNATURE
<u>John A. [Signature]</u> | | | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

4

Handwritten text at the top of the page, mostly illegible due to fading. Some words like "The" and "of" are visible.

Handwritten text in the middle section, appearing as several lines of cursive script.

Handwritten text at the bottom of the page, including what appears to be a signature or date.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 3 4 0 3 2
REG. NO. | | | | | |
|--|--|--|--|--|---|---|--|--|---|--|--|-----------------------------|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR | |
| I. DECEASED NAME FIRST MIDDLE LAST
JESSE C. JOHNSON | | | | | | | | | | Dec. 23, 1984 | | | | 10:45 PM | |
| 3 SEX
Male | | | 4 RACE
White | | | 5. DATE OF BIRTH MONTH DAY YEAR
Feb. 22 1894 | | | 6 AGE (IN YEARS LAST BIRTHDAY)
90 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington(State) | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | | |
| 10 CITY OR TOWN OF DEATH
Bethesda | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5900 Bradley Blvd | | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Director | | | 12b. KIND OF BUSINESS OR INDUSTRY
Gov't. (A.E.C.) | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS / ZIP CODE
5900 Bradley Blvd. 20814 | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | | 13c. CITY OR TOWN
Bethesda | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
R. R. Johnson | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary Rosebush | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII 531-10-8396 | | | 17. INFORMANT ADDRESS
Md.
Virginia J. Jeffers, 6317 Mass. Ave., Beth. | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia
DUE TO, OR AS A CONSEQUENCE OF
(b) Carcinoma urinary bladder
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 Wks.
8 Yrs. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. certify that (I) (this hospital) attended the deceased from 19 76, to 12/23 84, that (I) (we) last saw the deceased alive on 12/23 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Thomas L. Hartman
DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED
12/24/84 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Thomas L. Hartman, M.D. | | | | | | | | | | 22e. ADDRESS
3301 NM Ave. NW Wash., DC 20016 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | | 23b. DATE
12/28/84 | | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland Maryland | | | | | | |
| 24 FUNERAL DIRECTOR Joseph Gawler's Sons Inc.
NAME ADDRESS
5130 Wisc. Ave., N.W. Wash., D.C. | | | | | | | | | | 25a. DATE REC'D BY REGISTRAR
JAN 3 1985 | | | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Rodgers | |



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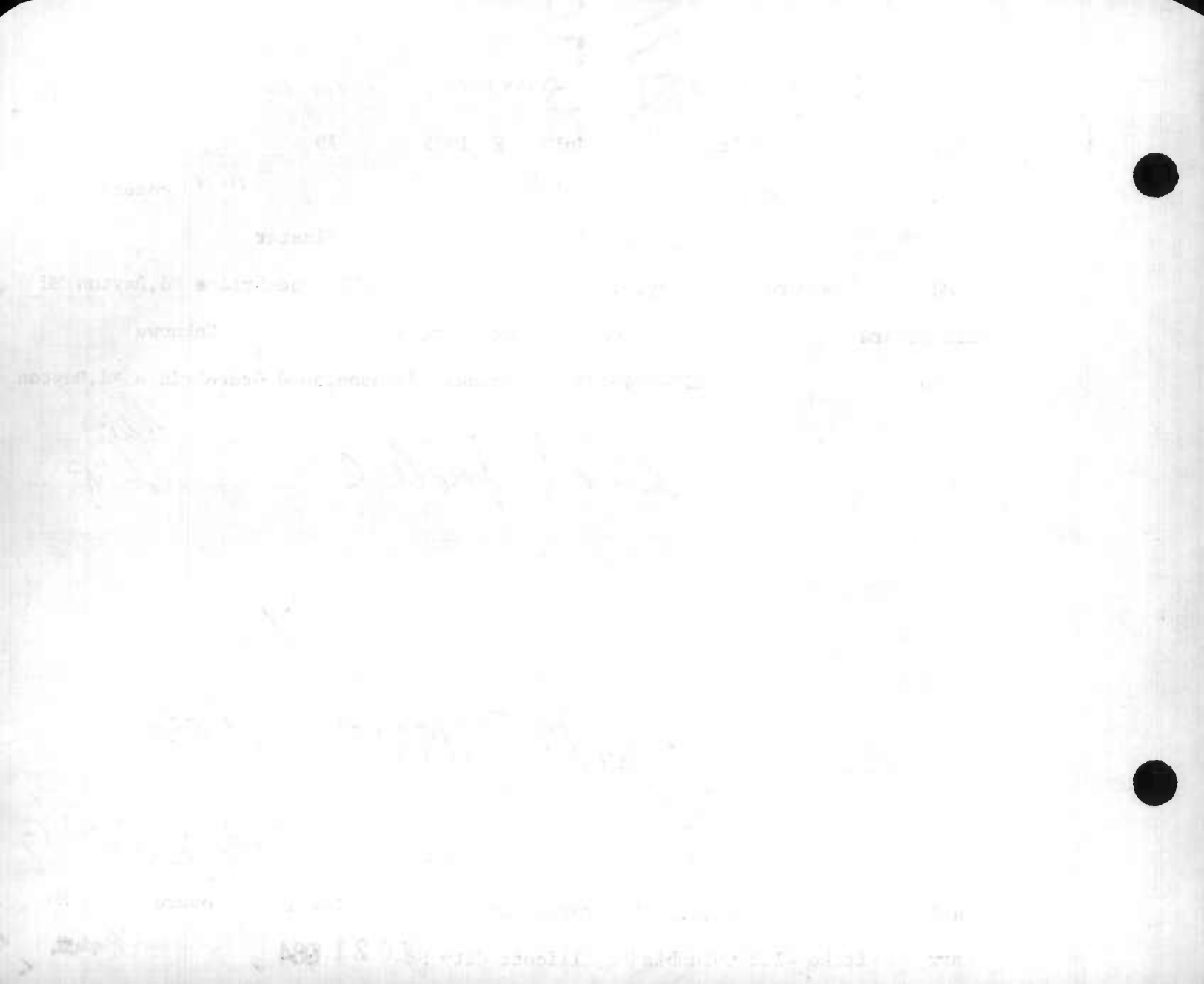
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 34033

FOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
LORENZO D JOHNSON | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/20/84 | | 2b. HOUR
MIN
1:50 AM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 9 1905 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
79 | | 7. UNDER 1 YEAR
MONTHS DAYS
YRS | | 8. UNDER 24 HRS
HOURS MIN
YRS | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md | | 10. CITIZEN OF WHAT COUNTRY?
USA | | 11. BALTIMORE CITY OR COUNTY OF DEATH
MONT gomery MD. | |
| 12. CITY OR TOWN OF DEATH
BETHESDA | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SUBURBAN HOSP | | 14. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Plaster | |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
15a. STATE
Md | | 15b. COUNTY
Howard | | 15c. CITY OR TOWN
Dayton | |
| 16. FATHER'S NAME
FIRST MIDDLE LAST
Late Howard Johnson | | 17. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Late Bertha Unknown | | 18. STREET ADDRESS / ZIP CODE
5080 Greenbridge Rd, Dayton Md 21036 | |
| 19. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 20. SOCIAL SECURITY NO.
217-094-133 | | 21. INFORMANT
ADDRESS
Michael Johnson, 5080 Greenbridge Rd, Dayton | |
| 22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Nephrosis
DUE TO, OR AS A CONSEQUENCE OF (b) Renal failure
DUE TO, OR AS A CONSEQUENCE OF (c) Deep | | | | | APPROXIMATE INTERVAL
BETWEEN CAUSE AND DEATH
1 day |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | |
| 23a. DATE OF OPERATION | | 23b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 23c. AUTOPSY
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 23d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 23e. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 23f. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 23g. INJURY OCCURRED
AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 23h. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 23i. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 23j. I certify that (I) (this hospital) attended the deceased from 12/19/84 to 12/20/84 and that in my (my) opinion death occurred on the date and hour and from the causes stated above. (If not, state (did not) view the body after death.) | | | | | |
| 23k. SIGNATURE
Thos G. WARD | | 23l. PHYSICIAN'S NAME (TYPE OR PRINT)
Thos G. WARD | | 23m. DATE SIGNED
12/20/84 | |
| 23n. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23o. DATE
Dec 22, 1984 | | 23p. NAME OF CEMETERY OR CREMATORY
Providence | |
| 23q. LOCATION
CITY OR TOWN
Glenelg | | 23r. COUNTY
Howard | | 23s. STATE
MD | |
| 24. FUNERAL DIRECTOR
NAME
Harry H Witzke | | 24a. ADDRESS
4112 Columbia Rd, Ellicott City Md | | 24b. DATE REC'D. BY REGISTRAR
DEC 21 1984 | |
| 24c. REGISTRAR'S SIGNATURE
John Davidson | | 24d. REGISTRAR'S SIGNATURE
John Davidson | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 34034 | | | |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST
Mary Louise Johnson | | | | November 30, 1984 | | | |
| 3. SEX FEMALE | | | | 2b. HOUR 8:13 PM | | | |
| 4. RACE WHITE | | | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 | | | |
| 5. DATE OF BIRTH JAN. 2, 1917 | | | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY, MD. | | | |
| 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) H. Maker | | | |
| 10. CITY OR TOWN OF DEATH OLNEY | | | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MONTGOMERY GENERAL HOSPITAL | | | | 13a. STREET ADDRESS 3020 Bel Pre Road 20902 | | | |
| 13a. STATE Md. | | | | 13b. CITY OR TOWN Wheaton | | | |
| 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 14. FATHER'S NAME FIRST MIDDLE LAST FRANK D. WALTER | | | |
| 15. MOTHER'S MAIDEN NAME MARGUERITE Fee | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | |
| 16b. SOCIAL SECURITY NO. 055-10-6813 | | | | 17. INFORMANT ADDRESS 1790 S. Emerson Denver, Col. 80210 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for each part)
PART I. DEATH WAS CAUSED BY: SEPTICEMIA | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days | | | |
| IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF | | | | 5 days | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ASPIRATION PNEUMONIA | | | | months | | | |
| (c) MALNUTRITION | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/30/84 to 11/30/84, that (I) (we) last saw the deceased alive on 11/30/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) see the body after death. | | | | | | | |
| 22b. SIGNATURE OF PHYSICIAN C.H. Ligon | | | | DEGREE MD | | 22c. DATE SIGNED 11/30/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) C.H. Ligon | | | | 22e. ADDRESS 18111 P+Phitpdx. Olney Md 20852 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE DEC. 1, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY Balt. Wash. Crem. | | 23d. LOCATION Laurel P. George Md. STATE | |
| 24. FUNERAL DIRECTOR NAME FRANCIS H. BARBER LAYTONSVILLE, MD. 20879 | | | | 25a. DATE REC'D. BY REGISTRAR 05 NOV 1984 | | | |
| 25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodarte | | | | | | | |



COOPERATION
X



RECEIVED

DATE

TIME

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be delivered for use at the burial-transit permit. Then please remove carbonpages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

34035

| | | | | | |
|--|--|---|--|-------------------------------|--|
| 1. FOR
STATE
REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Nina Arlene Johnson | | 12 19 84 | | 1:00 p. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YEAR | |
| Female | White | Feb. 22, 1926 ^{AR} | 58 | MONTHS DAYS HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 9. CITIZEN OF WHAT COUNTRY? | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 11. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Pennsylvania | U.S.A. | | Montgomery MD. | | |
| 12. CITY OR TOWN OF DEATH | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | 14. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORK) | 15. KIND OF BUSINESS OR INDUSTRY | | |
| Gaithersburg | 9428 Hickory View Place | Retired Title Clerk | | | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | 17. STATE | 18. COUNTY | 19. CITY OR TOWN | 20. STREET ADDRESS | |
| Maryland | Montgomery | Gaithersburg | INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 9428 Hickory View Place 20879 | |
| 21. FATHER'S NAME | 22. MOTHER'S MAIDEN NAME | 23. INFORMANT ADDRESS | | | |
| Claire J. Wolfe | Jennie Mae Fuller | Patricia Dennis same as 13e | | | |
| 24. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 25. SOCIAL SECURITY NO. | 26. IF YES, GIVE WAR OR DATES | | | |
| No | 246-20-0147 | | | | |
| 27. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Bronchogenic Carcinoma</i>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <i>18 mo</i> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Brain + liver metastasis.</i> | | | | | |
| 28. DATE OF OPERATION | 29. CONDITION FOR WHICH OPERATION WAS PERFORMED | 30. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 31. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 32. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | 33. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 34. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 35. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 36. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | 37. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 38. I certify that (I) <i>(was hospital)</i> attended the deceased from <i>March</i> , 19 <i>83</i> , to <i>19 Dec 84</i> , that (I) <i>(was)</i> lost saw the deceased alive on <i>16 Nov 84</i> , and that in (my) <i>(own)</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>(we)</i> did not view the body after death. | | | | | |
| 39. SIGNATURE | 40. DEGREE | 41. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 42. DATE SIGNED | | |
| <i>Donald E. Dillon</i> | <i>MD.</i> | | <i>20 Dec 84</i> | | |
| 43. PHYSICIAN'S NAME (TYPE OR PRINT) | 44. ADDRESS | | | | |
| Donald E. Dillon | 1811 Prince Phillip Dr. Olney, Md. 20832 | | | | |
| 45. BURIAL, CREMATION, REMOVAL | 46. DATE | 47. NAME OF CEMETERY OR CREMATORY | 48. LOCATION CITY OR TOWN COUNTY STATE | | |
| Burial | 12/22/84 | Parklawn Memorial Park | Rockville, Maryland | | |
| 49. FUNERAL HOME | | 50. DATE REC'D. BY REGISTRAR | 51. REGISTRAR'S SIGNATURE | | |
| Tyson Wheeler Funeral Home, Inc.
1331 Rockville Pike, Rockville, Md. 20852 | | DEC 28 1984 | <i>Johanna Davidson-Randall</i> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

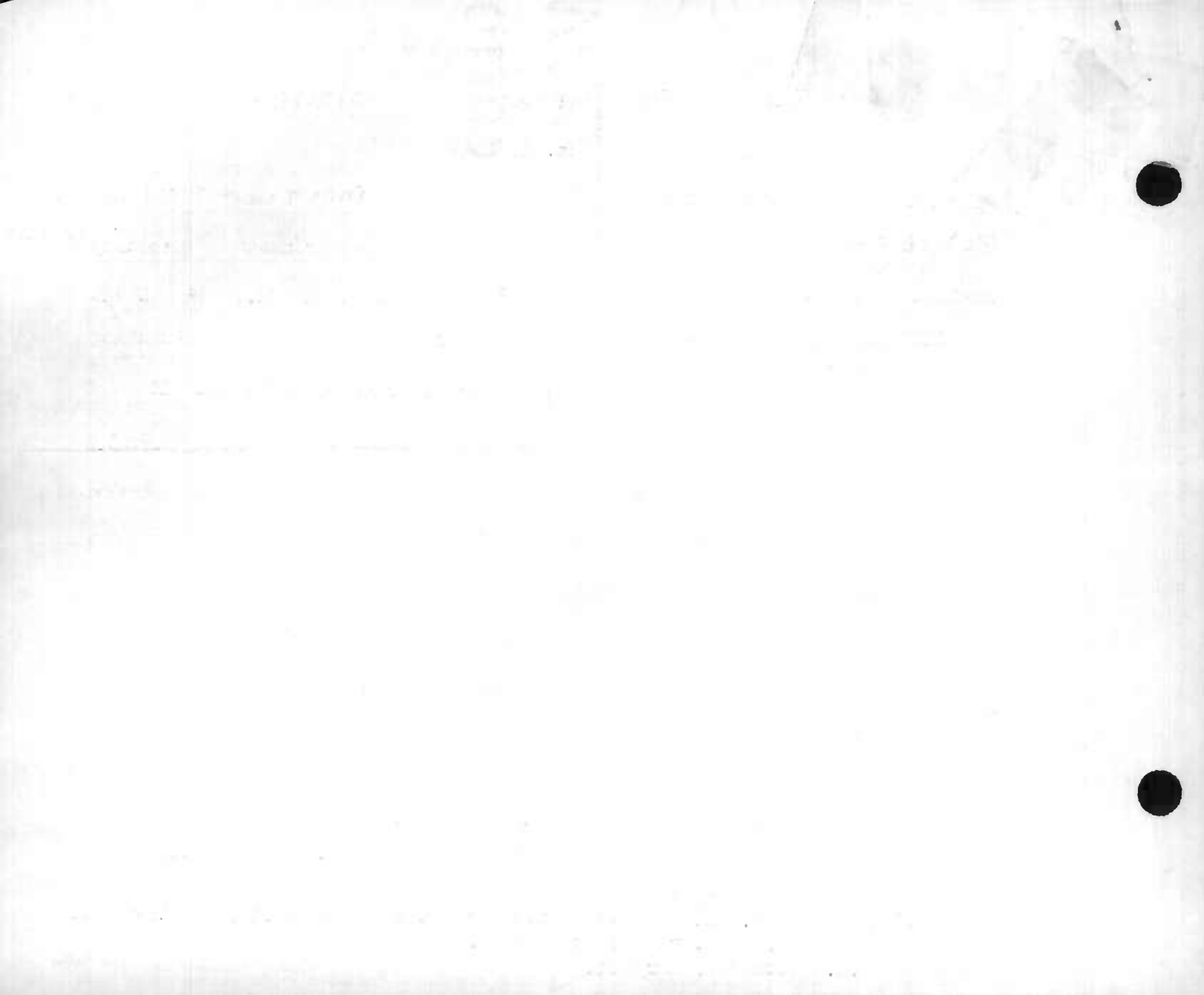
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/83
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 3 4 0 3 6 | | | |
|---|--|--|--|---|--|---|--|--------------------------------|--|------------------|-----|--|----------|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| RUSSELL Drenning JOHNSON | | | | | | | | 12/31/84 | | | | | 812 M |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| Male | | Caucasian | | Oct. 1, 1910 | | 74 | | MONTHS | | DAYS | | HOURS | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Delaware | | United States | | | | MONTGOMERY County MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| BETHESDA | | SUBURBAN Hospital | | Partner/Mason | | Masonry | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | | | |
| Maryland | | Montgomery | | Chevy Chase | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 4406 Elm St., zip 20815 | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| FIRST MIDDLE LAST William Johnson | | FIRST MIDDLE LAST Carrie Drenning | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | |
| no | | 066 10 2235A | | Barbara B. Johnson, wife, see #13 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardio-respiratory failure</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>A/B her mother's disease</u> | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>3 days</u>
<u>3 days</u>
<u>0-4 hrs</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 21</u> , 19 <u>81</u> , to <u>31 Dec</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>30 Dec</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
<u>John M. Hyman</u> | | DEGREE
<u>MD</u>
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>12/31/84</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | |
| Cremation | | 198 <u>4</u>
Dec. 31, | | Metropolitan Crematory | | Alexandria, Virginia | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Robert A. Pumphrey Funeral Homes,
P.A. Bethesda, Maryland | | JAN 2 1985 | | Julia Davidson-Randall | | | | | | | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 34037 | | | | | |
|--|--|--|--|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MINNIE OVELLA JURNEY | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 12 1984 | | | 2b. HOUR
12:45 P_M | | | | | | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
FEBRUARY 8 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NORTH CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | | | | 13b. COUNTY
PRINCE GEO'S | | 13c. CITY OR TOWN
CLINTON | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
CHRISTOPHER COLUMBUS HARTNESS | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY JANE CHAPPELL | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
--- | | 17. INFORMANT
ADDRESS
FRANK C. JURNEY, SR., 4411 MORGAN ROAD, | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 6 19 84 to DECEMBER 12 19 84 that (I) (we) last saw the deceased alive on DECEMBER 12 19 84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>B. J. Kelly</i> B. J. KELLY | | | | DEGREE
MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
13 DEC 84 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
B. J. KELLY, LT, MC, USNR | | | | | | 22e. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND,
NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
15 Dec 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland PG MD | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Robert E. Wilhelm Funeral Home | | | | | | ADDRESS
Suitland, Md. | | 25a. DATE REC'D. BY REGISTRAR
DEC 31 1984 | | | | | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
<i>John Davidson</i> | | | | | | | | | |

BP _____

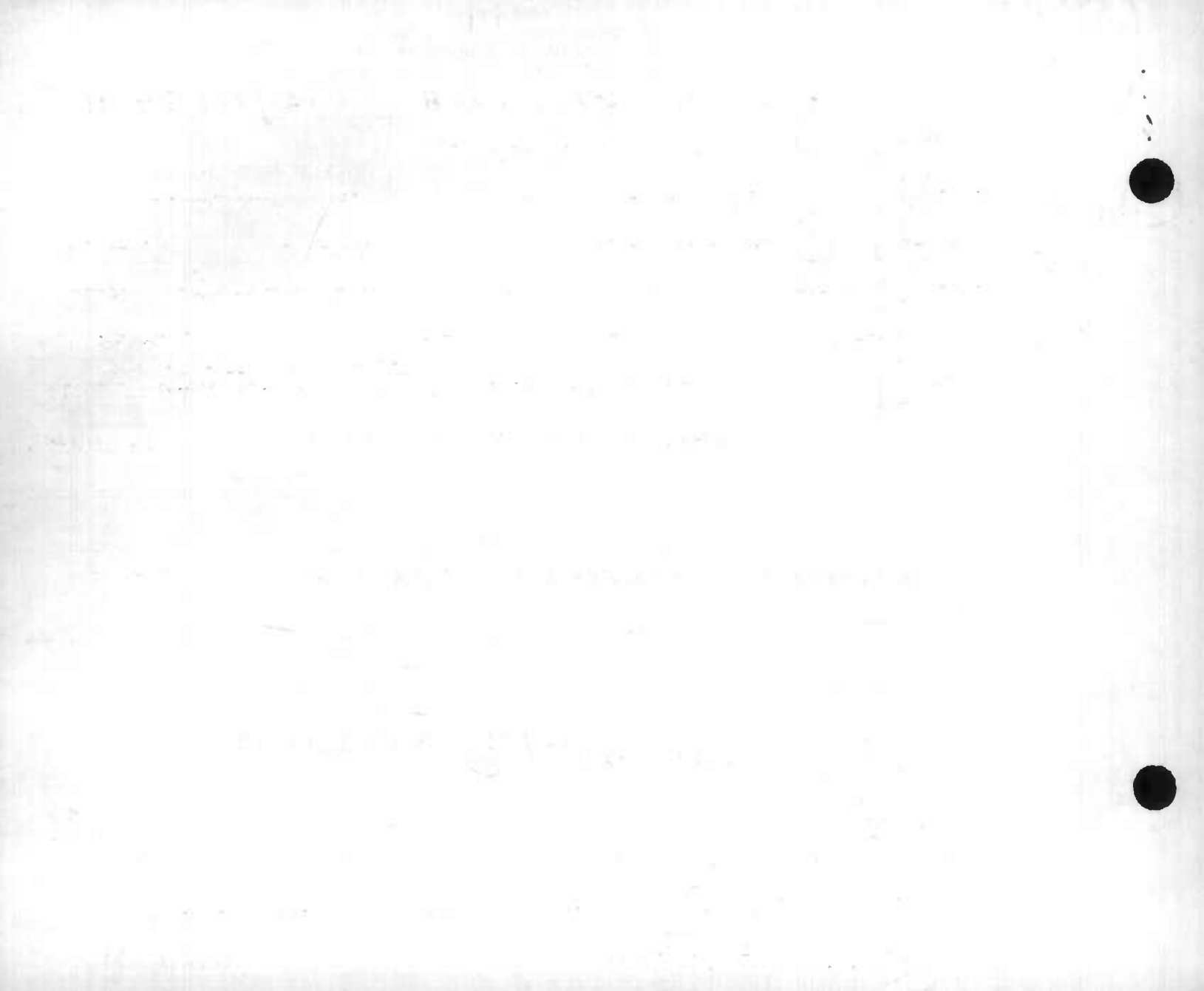


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Page 3 should be filed with the funeral director. Page 4 should be filed with the funeral director within 72 hours after death. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 4 0 3 8
REG. NO.

| | | | | | |
|---|--|--|--|---|--|
| 1- FOR STATE REGISTRAR | | 2a DATE OF DEATH | | 2b HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | P M | |
| FIRST MIDDLE LAST | | 12/13/84 | | 11 P | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | |
| Female | | Caucasian | | MONTH DAY YEAR | |
| | | | | Feb, 15, 1896 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. AGE (IN YEARS LAST BIRTHDAY) | |
| Michigan | | United States | | 88 YRS. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Bethesda | | Suburban Hospital | | Montgomery County, MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Teacher | | Education | | | |
| 13a. STATE | | 13b. CITY OR TOWN | | 13c. STREET ADDRESS / ZIP CODE | |
| Michigan | | Washtenaw | | Gregory 12310 Hadley Road 48317 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | |
| Harrison | | Hadley | | Flora Goodwin | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | 374 26 5896 | | Daughter 6500 Westland Road Bethesda, Maryland 20817 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF (b) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| CEREBRO VASCULAR ACCIDENT | | | | 14 HOURS | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| OSTEOPOROSIS, COMPRESSION FRACTURES OF SPINE | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from 12/13, 19 84, to 12/13, 19 84, that (we) lost saw the deceased alive on 12/13, 19 84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (b) we (did) (did not) view the body after death. | | 22b. SIGNATURE OF PHYSICIAN | | 22c. DATE SIGNED | |
| | | Ralph M. Conn MD | | 12/14/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| RALPH M. CONN MD | | 4400 EAST WEST HWY BETHESDA, Md. 20814 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | Dec. 17, 1984 | | Unadilla Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE | | 23e. DATE REC'D. BY REGISTRAR | | 23f. REGISTRAR'S SIGNATURE | |
| Unadilla, Michigan | | DEC 18 1984 | | Shirley Davidson-Randall | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | 24a. DATE REC'D. BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | |
| ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND | | DEC 18 1984 | | Shirley Davidson-Randall | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 3 4 0 3 9
REG. NO. | |
|---|--|--|--|---|--|--|--|---|--|-----------------------------------|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Selma B. Kaplan | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12-20-84 | | 7b. HOUR
3 30 P.M. | |
| 3. SEX
FEMALE | | 4. RACE
Cauc. | | 5. DATE OF BIRTH MONTH DAY YEAR
10 27 02 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 1 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Illinois | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Potomac | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
10708 Great Arbor Dr. 20854 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Marcus Blair | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Esther (Unknown) | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
unKN | | | |
| 16b. SOCIAL SECURITY NO.
346-05-5890 | | | | 17. INFORMANT ADDRESS
Lawrence A. Kaplan; 10708 Great Arbor Drive Potomac, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory failure
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF (c) renal insufficiency, Hypertension, Diabetes
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO: WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21i. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from 12/11 19 84 to 12/20 19 84 , that (b) (we) lost saw the deceased alive on 12/20 19 84 , and that in (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above (b) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Peter Sherer md | | | | DEGREE
MD | | | | 22c. DATE SIGNED
12/20/84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Peter Sherer md | | | | 22e. ADDRESS
3947 Ferrara Dr. Wheaton, md | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12-23-1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Judean Memorial Gardens | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Olney, Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME
Danzansky-Goldberg Chapels; 1170 Rockville Pike | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 24 1984 | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

BP _____

18-12-21
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

34040
REG. NO.

1- FOR STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST *Josephine Emma Kates*

2a. DATE OF DEATH MONTH DAY YEAR *12-28-84* 2b. HOUR *1:10* M

3. SEX *Female* 4. RACE *Black* 5. DATE OF BIRTH MONTH DAY YEAR *1-23-14* 6. AGE (IN YEARS LAST BIRTHDAY) *70* YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) *North Carolina* 7b. CITIZEN OF WHAT COUNTRY? *USA* 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH *PG MONT.* MD.

10. CITY OR TOWN OF DEATH *Takoma Park, Md.* 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) *Washington Adventist Hospital* 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) *none* 12b. KIND OF BUSINESS OR INDUSTRY

13a. STATE *Maryland* 13b. COUNTY *P.G.* 13c. CITY OR TOWN *Chillum* 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ 13e. STREET ADDRESS / ZIP CODE *6505 Ninth Avenue 20783*

14. FATHER'S NAME FIRST MIDDLE LAST *Henry Torrence* 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST *Maggie Gray*

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) *no* 16b. SOCIAL SECURITY NO. *236 30 6002* 17. INFORMANT ADDRESS *6505 Ninth Avenue-Chillum, Md.*
Mrs. Eleanor K. Torrain-daughter

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) *Massive C.V.A.*
DUE TO, OR AS A CONSEQUENCE OF (b) *Respiratory failure.*
DUE TO, OR AS A CONSEQUENCE OF (c) *Renal failure.*

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
Fractured hip.

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 19c. AUTOPSY? YES ☐ NO ☒ 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR *Nov. 10, 1984* P.M. 19 *84* 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21a. INJURY OCCURRED WHILE ☐ AT WORK NOT WHILE ☐ AT WORK 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21c. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from *Nov. 10, 1984* to *Dec. 28, 1984*, that (I) (we) lost saw the deceased alive on *Dec. 27, 1984*, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE *Miguel A. Rodriguez* DEGREE *ATTENDING PHYSICIAN* ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED *12/28/84*

22d. PHYSICIAN'S NAME (TYPE OR PRINT) *MIGUEL A. RODRIGUEZ* 22e. ADDRESS *831 University Blvd. S. Spring*

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) *Burial* 23b. DATE *Jan 2, 1985* 23c. NAME OF CEMETERY OR CREMATORY *Kanawha Valley* 23d. LOCATION CITY OR TOWN COUNTY STATE *Valley Garden Memorial Glasgow, West Virginia*

24. FUNERAL DIRECTOR NAME *John T. Stewart, Jr.* 24a. DATE REC'D BY REGISTRAR *JAN 2 1985* 24b. ADDRESS *Stewart Funeral Home 4001 Benning Road, NE.*



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH34041
REG. NO.FOR
1 - STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|--|--|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Gilbert NEFF Keller | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 12 1984 | | | 2b. HOUR
8:50 PM | | | |
| SEX
MALE | | 4 RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
OCT. 24. 1907 | | 6 AGE (IN YEARS LAST BIRTHDAY)
77 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
PLUMBING BUSINESS (RET.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE
D.C. | | 13b. COUNTY
WASHINGTON | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
7049 31st. ST. N.W. 20015 | | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
GILBERT M. KELLER | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
IRATHERINE ACKER | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
YES W.W.II | | 16b. SOCIAL SECURITY NO.
578-05-5238 | | 17 INFORMANT ADDRESS
MARY M. KELLER, 7049 31st. ST. N.W. D.C. | | | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ADDIC (BRAIN DAMAGE)
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) cardio pulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF
(c) Chronic obstructive lung disease on pulmonary years
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Chronic liver Hepatomegaly | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from
saw the deceased alive on 12-12-1984 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Jason Greiber, MD | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12.13.84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JASON GREIBER, MD | | | 22e. ADDRESS
4030 CAMERON STREET SILVER SPRING MD. 20910 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
Dec. 15. 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Bethesda P.D. Md | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Takara Funeral Home 234 Cameron St. N.W. WASH DC 20015 | | | | | | | | | |
| 25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
DEC 17 1984 Julia Davidson-Randall | | | | | | | | | |

YES M. W. II 28-12-238 MARY M. KENNEL TOWN 314 ST. W. 40
 GURDET M. KENNEL KATHARINE JONES
 D.C. KENNEL TOWN 314 ST. W. 40
 YES M. W. II 28-12-238 MARY M. KENNEL TOWN 314 ST. W. 40
 GURDET M. KENNEL KATHARINE JONES
 D.C. KENNEL TOWN 314 ST. W. 40



Original - This is 1914 for the County of ...
 ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

F

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 4 0 4 2

| | | | | | | | | | | |
|--|--|--|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
DEWAYNE MARION KELLY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 31 1984 | | | 2b. HOUR
6:20 | | | | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
JULY 30 1931 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
53 | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
COLORADO | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S.M.C. | | |
| 13a. STATE
VIRGINIA | | | 13b. COUNTY
FAIRFAX | | 13c. CITY OR TOWN
ALEXANDRIA | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
6405 GENTELE COURT 22310 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOSEPH MARION KELLY | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MABEL MITILDA THOMPSON | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
1950-1971 | | 17. INFORMANT
ADDRESS
SHIRLEY J. KELLY, 6405 GENTELE COURT, | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 29 19 84 to DECEMBER 31 19 84 , that (I) (we) last saw the deceased alive on DECEMBER 31 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Brown (7/16) | | | | | DEGREE
MD
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
31 DEC 84 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
B.L. FLAX, LT, MC, USNR | | | | | 22e. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND,
NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | 23b. DATE
1-2-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria, Va. | | |
| 24. FUNERAL DIRECTOR
NAME
Everly-Wheatley | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 4 1985 | | | | | |
| 1500 W. Braddock Rd. Alex. Va. | | | | | | | | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 4 0 4 3
REG. NO.1- FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|---|---|---|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) JOHN R. Kelly | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-13-84 | | | 2b. HOUR
P M
11:00 P | | | | |
| 3. SEX
MALE | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
8-31-97 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS MONTHS DAYS
87 | | IF UNDER 1 YEAR
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Accountant | | 12b. KIND OF BUSINESS OR INDUSTRY
I.R.S. | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Kensington | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
5009 Aurora Drive 20895 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James B. Kelly | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rose Hyland | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW I | | 17. INFORMANT
Hester I. Kelly | | ADDRESS
Wife Same as 13 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute aspiration pneumonia | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24h | | |
| DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Orbicularis carnicularis, Dura | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/12 19 84 to 12/13 19 84 , that (I) (we) last saw the deceased alive on 12/13 19 84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Myron L. Lenkin | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
1/14/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MYRON L. LENKIN | | | | 22e. ADDRESS
2309 STOREFIELD RD WHEATON, MD. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec. 17, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring Mont. Md. | | | | |
| 24. FUNERAL DIRECTOR
NAME
Francis J. Collins | | | | ADDRESS
500 University Blvd., W. Silver Spring, Md. | | 25a. DATE REC'D. BY REGISTRAR
DEC 19 1984 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3 4044

| | | | | | | | | | |
|---|-------------------------|--|-------------------------------------|---|--------------------------------|--|---|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
Zabel Kibrityan | | | | | | 2a. DATE KNOWN OF DEATH
Dec. 21, 1984 | | 2b. HOUR
AM | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
August 15 1916 | 6. AGE (IN YEARS)
68 YRS. | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
Dec. 22 1984 | | 2d. HOUR
12 AM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Turkey | | 7b. CITIZEN OF WHAT COUNTRY?
Turkey | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | | |
| 10. CITY OR TOWN OF DEATH
Gaithersburg | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
101 Oden'Hal Road | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 13a. STATE
Md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
101 Oden'Hal Road 20877 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Garabed Enfiedian | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
Unknown | | 17. INFORMANT
Mari M. Kibrityan | | ADDRESS
2112 MacArthur Blvd Washington, D.C. N.W. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) CORONARY ARTERIOSCLEROSIS
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2-3 DAYS
INDEF | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
_____ | | | | | | | | | |
| 19a. DATE OF OPERATION
_____ | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
_____ | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
EARLY AM 12 21 1984 FOUND DEAD IN BED | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
12 21 1984 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
FOUND DEAD IN BED | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
HOME | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
101 Oden'Hal Rd Gaithersburg MONT MD | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Francis C. Mayle</i> | | TITLE (SPECIFY)
DEPT M.D. | | | | MEDICAL EXAMINER | | DATE SIGNED
12/22/84 | |
| EXAMINER'S NAME (TYPE OR PRINT)
Francis C. Mayle, M.D. | | ADDRESS
8200 WI. Ave. Beth, MD20814 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SEE PW)
Burial | | 23b. DATE
12/24/1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Memorial Park Cem. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville Maryland | | |
| 24. FUNERAL DIRECTOR
NAME
Jos eph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Wash., D.C. | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 28 1984 | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
<i>John L. Anderson</i> | | | |



Handwritten text, possibly a signature or date, oriented vertically.

DEC 28 1964
U.S. DEPARTMENT OF THE ARMY
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 34045
REG. NO. | | |
|--|--|--|-----------|--|------------------------------------|--|---|---|----------|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | FIRST MIDDLE LAST | | 12 22 84 | | 6:18 AM | | | |
| Priscilla Ann KICHEREIR | | | | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | |
| Female | | Caucasian | | March 24, 1921 | | 63 | | MONTHS DAYS | | HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| New York State | | U.S.A. | | | | MONTGOMERY CO MD | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Bethesda | | SUBURBAN | | | | Housewife | | Own home | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 5527 Surrey Street, 20015 | | | | |
| Maryland | | Montgomery | | Chevy Chase | | | | | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST | | | | | FIRST MIDDLE LAST | | | | | | | |
| Geoffrey Smith | | | | | Kathlyn Langsford | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| No | | | | | 4347-12-6263 | | Dr. Nancy Kicherer, Oak Park Rd., Madison, VA | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | 2-3 days | | |
| IMMEDIATE CAUSE (a) 18 Pneumonia, bronchogenic | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Alzheimer's Disease | | | | | | | | | | yrs. | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | |
| | | | | P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 77 to DEC 21 19 84, that (I) (we) last saw the deceased alive on 12/21 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | | |
| Daniel Rosenblum | | | | MD | | | | 12/22/84 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | | |
| DANIEL ROSENBLUM | | | | 10400 CONNECTICUT AVE KENSINGTON, MD 20895 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | | | |
| Burial | | | 12-27-84 | | Cedar Hill Cemetery | | | CITY OR TOWN COUNTY STATE | | | | |
| | | | | | | | | Madison VA | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| NAME ADDRESS | | | | | | 31 1984 | | John L. ... | | | | |
| Gloria Funeral Home | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 34040 | | | | | |
|--|--|---|--|--|--|---|--|---|--|---|---------------------------|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | 26. DATE OF DEATH MONTH DAY YEAR 12 / 26 / 84 | | | | | | | 26. HOUR 11 20 PM | |
| 1. DECEASED NAME (TYPE OR PRINT) FRANK WILLIAM KLANN | | | | | | | 27. DATE OF DEATH MONTH DAY YEAR 12 / 26 / 84 | | | | | | | 27. HOUR 11 20 PM | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 10 29 10 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) COLORADO | | 7b. CITIZEN OF WHAT COUNTRY? U-S-A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Torrance Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY Veterans Admin. | | | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. COUNTY Mont Co 13c. CITY OR TOWN Kensington 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 10517 EWELE AVE. 20895 | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST UNKNOWN MIDDLE LAST | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST UNKNOWN MIDDLE LAST | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES WWII | | | | | | | 16b. SOCIAL SECURITY NO. 700/03/3939 | | | | | | | 17. INFORMANT ADDRESS KAREN JOHNSTON, DAUGHTER, 523 7TH ST., S.E. WASHINGTON, D.C. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Tubular Necrosis | | | | | | | | | | | | 3 days | | | |
| (c) Squamous Cell Ca. of Lung | | | | | | | | | | | | weeks | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a None | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION None | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 15 19 84, to Dec 26 19 84, that (I) (we) last saw the deceased alive on 12/26 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Peter S. Birk M.D. | | | | | | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/27/84 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER S BIRK, M.D. | | | | | | | 22e. ADDRESS 10829 Ga. Av, Wheaton, Md 20902 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | | | 23b. DATE 12/27/84 | | 23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA VIRGINIA | | | | | |
| 24. FUNERAL DIRECTOR NAME RICHARD RAPP INC | | | | 1804 F ST., N.W. WASH., D.C. 20009 | | | | 25a. DATE REC'D. BY REGISTRAR JAN 4 1985 | | 25b. REGISTRAR'S SIGNATURE | | | | | |



CHAPMAN

DOX. COLL.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 17 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR STATE REGISTRAR | | | | | | | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | | | | | 2a. DATE KNOWN OF DEATH | | | | | | | | | |
| George T. Knight | | | | | | | | | | 12/17/84 | | | | | | | | | |
| 3. SEX | | | | | | | | | | 2b. HOUR | | | | | | | | | |
| M | | | | | | | | | | M | | | | | | | | | |
| 4. RACE | | | | | | | | | | 2c. DATE PRONOUNCED DEAD | | | | | | | | | |
| W | | | | | | | | | | Dec 21 1984 | | | | | | | | | |
| 5. DATE OF BIRTH | | | | | | | | | | 2d. HOUR | | | | | | | | | |
| Dec 13 29 | | | | | | | | | | 730 | | | | | | | | | |
| 6. AGE (IN YEARS) | | | | | | | | | | 2e. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| 55 YRS. | | | | | | | | | | Montgomery MD | | | | | | | | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | | | | | | |
| Connecticut | | | | | | | | | | | | | | | | | | | |
| 9. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| U.S. | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | | | | | | |
| Bil. Spg. | | | | | | | | | | 1101 Burnley Ter | | | | | | | | | |
| 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Machinist | | | | | | | | | | Auto | | | | | | | | | |
| 13a. STATE | | | | | | | | | | 13b. COUNTY | | | | | | | | | |
| MD | | | | | | | | | | Mont. | | | | | | | | | |
| 13c. CITY OR TOWN | | | | | | | | | | 13d. INSIDE CITY LIMITS? | | | | | | | | | |
| Bil. Spg. | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 13e. STREET ADDRESS | | | | | | | | | | 20902 | | | | | | | | | |
| 1101 Burnley Ter | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| George T. Knight | | | | | | | | | | Ruth Barnard | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | |
| Yes | | | | | | | | | | 367-28-7591 | | | | | | | | | |
| 16c. (IF YES, GIVE WAR OR DATES) | | | | | | | | | | 17. INFORMANT | | | | | | | | | |
| W Korean | | | | | | | | | | Ms. Carla Hibbard | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Acute & Chronic Alcoholism | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: | | | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | | | | | |
| None | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | |
| None | | | | | | | | | | | | | | | | | | | |
| 20. AUTOPSY? | | | | | | | | | | | | | | | | | | | |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS | | | | | | | | | | 21b. TIME OF INJURY | | | | | | | | | |
| UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | |
| | | | | | | | | | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 21f. LOCATION | | | | | | | | | | | | | | | | | | | |
| CITY OR TOWN | | | | | | | | | | COUNTY STATE | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on | | | | | | | | | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | |
| death resulted from: | | | | | | | | | | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | | | | | TITLE (SPECIFY) | | | | | | | | | |
| [Signature] | | | | | | | | | | M.D. Dep. MEDICAL EXAMINER | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | | | | | | | DATE SIGNED | | | | | | | | | |
| | | | | | | | | | | Dec 21/1984 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | | | | | 23b. DATE | | | | | | | | | |
| Removal | | | | | | | | | | 12/21/84 | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION | | | | | | | | | |
| | | | | | | | | | | CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | | | | | |
| NAME | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Anatomy Board | | | | | | | | | | Balto., Md. | | | | | | | | | |
| ADDRESS | | | | | | | | | | JAN 02 1985 Julia Davidson Randall | | | | | | | | | |

BP

RECEIVED

NOV 10 1964

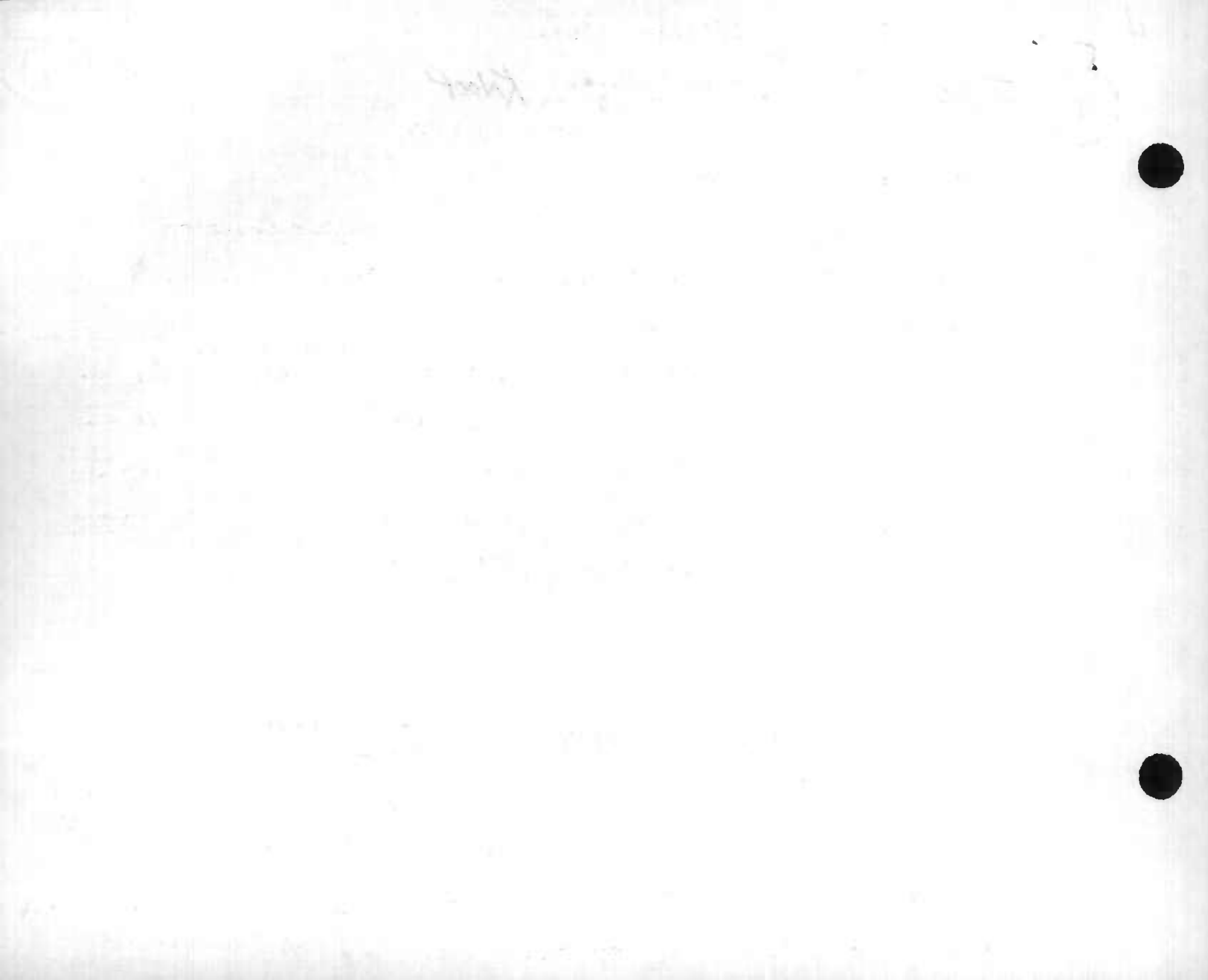
WASH DC



| FOR
1 - STATE
REGISTRAR | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | REG. NO. 34048 | |
|---|--|--|--|---|--|
| 1. DECEASED NAME
FIRST MIDDLE LAST
JACOB ROG KNOOP | | 7a. DATE OF DEATH
MONTH DAY YEAR
12-18-84 | | 7b. HOUR
3:09 P.M. | |
| 2. SEX
Male | | 4. RACE
White | | 6. AGE (IN YEARS (LAST BIRTHDAY))
77 YRS. | |
| 3a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Amsterdam | | 3b. CITIZEN OF WHAT COUNTRY?
Holland | | 5. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Walter Sheraton Hotel | |
| 13a. STATE
Md. | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
Kensington | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Simon Knoop | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rosalie Kinsbergen | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | |
| 16b. SOCIAL SECURITY NO.
577 52 3739 | | 17. INFORMANT
9207 Lawnview Lane
Bernhard Knoop (Son) Laurel, Md. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>renal failure</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>renal cell carcinoma</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 min
months
3 years. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.
<u>Ischemic conduction system</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) this hospital attended the deceased from <u>12/18</u> 19 <u>84</u> to <u>12/18</u> 19 <u>84</u> , that (1) (we) last saw the deceased alive <u>above</u> (above) (below) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Samuel D. Goldberg</u> | | TENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>12/18/84</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Samuel D. Goldberg M.D. | | 22e. ADDRESS
11125 Rockville Pike, Rockville, Md. 20852 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/21/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville Mont. Md. | | 24. FUNERAL DIRECTOR
NAME ADDRESS
Hines/Rinaldi 11800 New Hamp.Ave.S.S.Md. | | | |
| 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
UTC 21 1984 <u>Felia Davidson-Randall</u> | | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Their plates require carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH34049
REG. NO.

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) RAMONA ANN KOEBLER | | 2a. DATE OF DEATH
MONTH DAY YEAR 12-10-84 | | 2b. HOUR
700 P.M. | |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR 4 28 58 | | 6. AGE (IN YEARS LAST BIRTHDAY)
26 YRS. | |
| 7a. BIRTH PLACE
(STATE OR FOREIGN COUNTRY) MICHIGAN | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
TAKOMA PARK | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) OFFICE MGR | | 12b. KIND OF BUSINESS OR INDUSTRY
COND. CLOTHING |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
MD | 13b. COUNTY
P.G. | 13c. CITY OR TOWN
MT RANIER | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
3317 CHAUNCEY PL #301 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST ROGER L. KOEBLER | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST IMOGENE L. STILWELL | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
215-62-4831 | | 17. INFORMANT
FATHER ADDRESS 7003 22ND AVENUE HYATTSVILLE, MD. 20783 | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Thrombotic CNS disease**DUE TO, OR AS A CONSEQUENCE OF (b) **sub acute endocarditis**

DUE TO, OR AS A CONSEQUENCE OF (c)

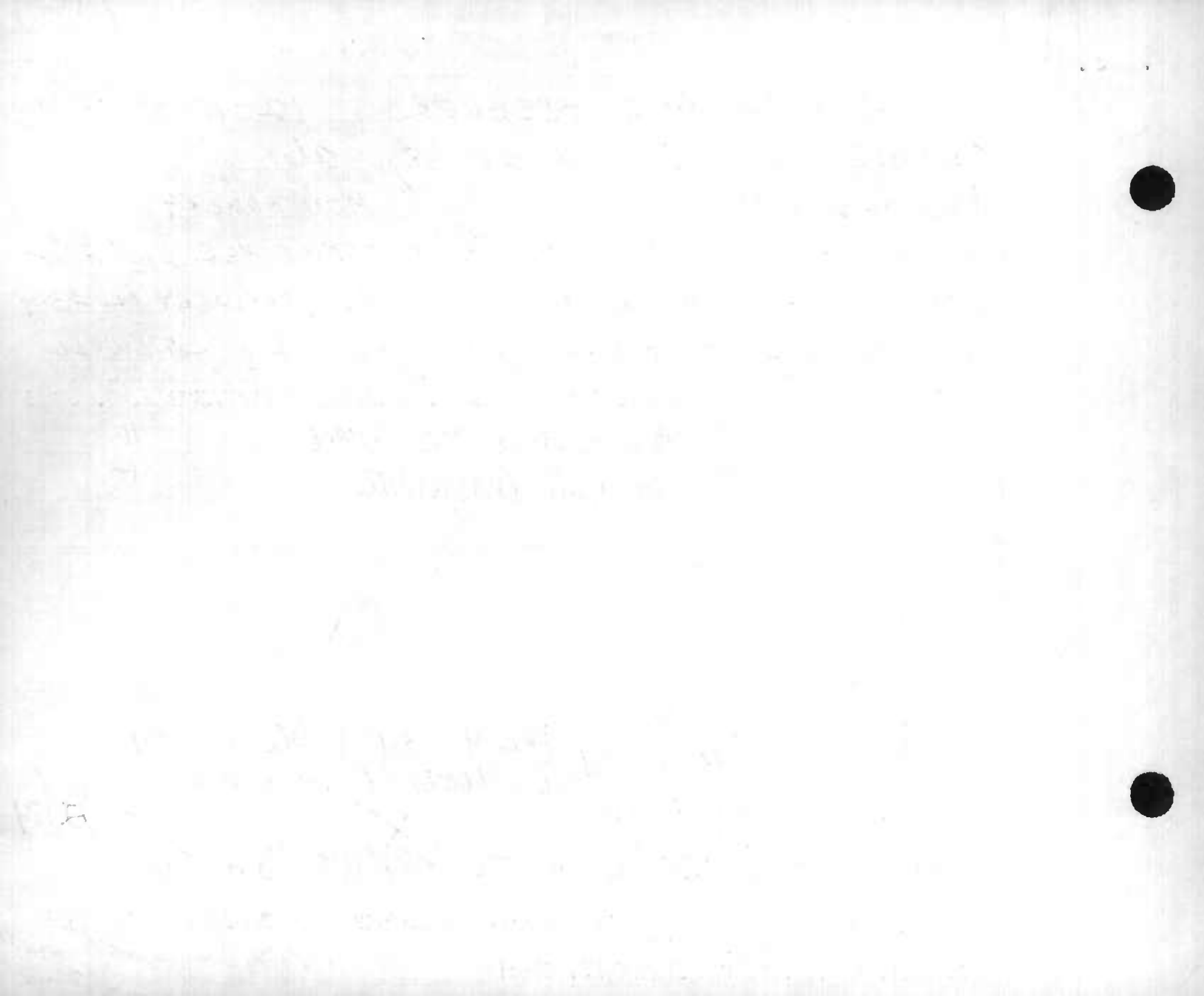
APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**1h****h**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

| | | | | | |
|--|--|--|--|--|---|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 11 1984 to Dec 11 1984 , that (I) (we) last saw the deceased alive on Dec 11 1984 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Martin J. Neltz Jr. | | 22c. DATE SIGNED
12/15/84 | | 22d. ATTENDING MEDICAL STAFF
PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
MARTIN D. NELTZ | | 22f. ADDRESS
7525 Greenway Cir Greenbelt MD 20770 | | | |

| | | | |
|--|------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) CREMATION | 23b. DATE
12/15/84 | 23c. NAME OF CEMETERY OR CREMATORY
METROPOLITAN CREMATORY | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ALEXANDRIA VIRGINIA |
| 24. FUNERAL DIRECTOR
NAME FRANCIS J. COLLINS
ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | 25a. DATE REC'D. BY REGISTRAR
DEC 19 1984 | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|---|--|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 3 4 0 5 0
REG. NO. | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH
MONTH DAY YEAR | | 2b. HOUR | |
| Mildred | | | | | | Koplow | | December 4, 1984 | | 10:00a | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH
MONTH DAY YEAR | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| Female | | Caucasian | | April 22, 1924 | | 60 YRS | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| South Carolina | | USA | | | | Montgomery MD | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Potomac | | 8908 Liberty Lane | | | | | | Editor | | PIA | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET ADDRESS | |
| Maryland | | Montgomery | | Potomac | | | | 8908 Liberty Lane | | 20854 | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | | | |
| H. Pierce Gault | | Ruth Travis Brown | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17 INFORMANT | | ADDRESS | | | | | |
| No | | N/A | | 249 22 7515 | | George Koplow same as #13 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Lung</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>metastatic carcinoma of bones</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>respiratory failure</u> | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Anemia, cachexia, pneumonia</u> | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a I certify that (I) (the medical examiner) attended the deceased from <u>July</u> 19 <u>84</u> to <u>DECEMBER</u> 19 <u>84</u> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <u>December 1</u> 19 <u>84</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>D. O. Jones</u> | | DEGREE
ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/>
PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED
12-4-84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dai Yoo, M.D. | | 22e. ADDRESS
Potomac, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| Cremation | | Dec. 4, 1984 | | Metroplitan Crematory | | Alexandria, Virginia | | | | | |
| 24 FUNERAL DIRECTOR
NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Ives-Pearson Funeral Homes, Arlington, Va. | | | | JUL 11 1984 | | John A. ... | | | | | |



[Faint, illegible handwritten text or signature]

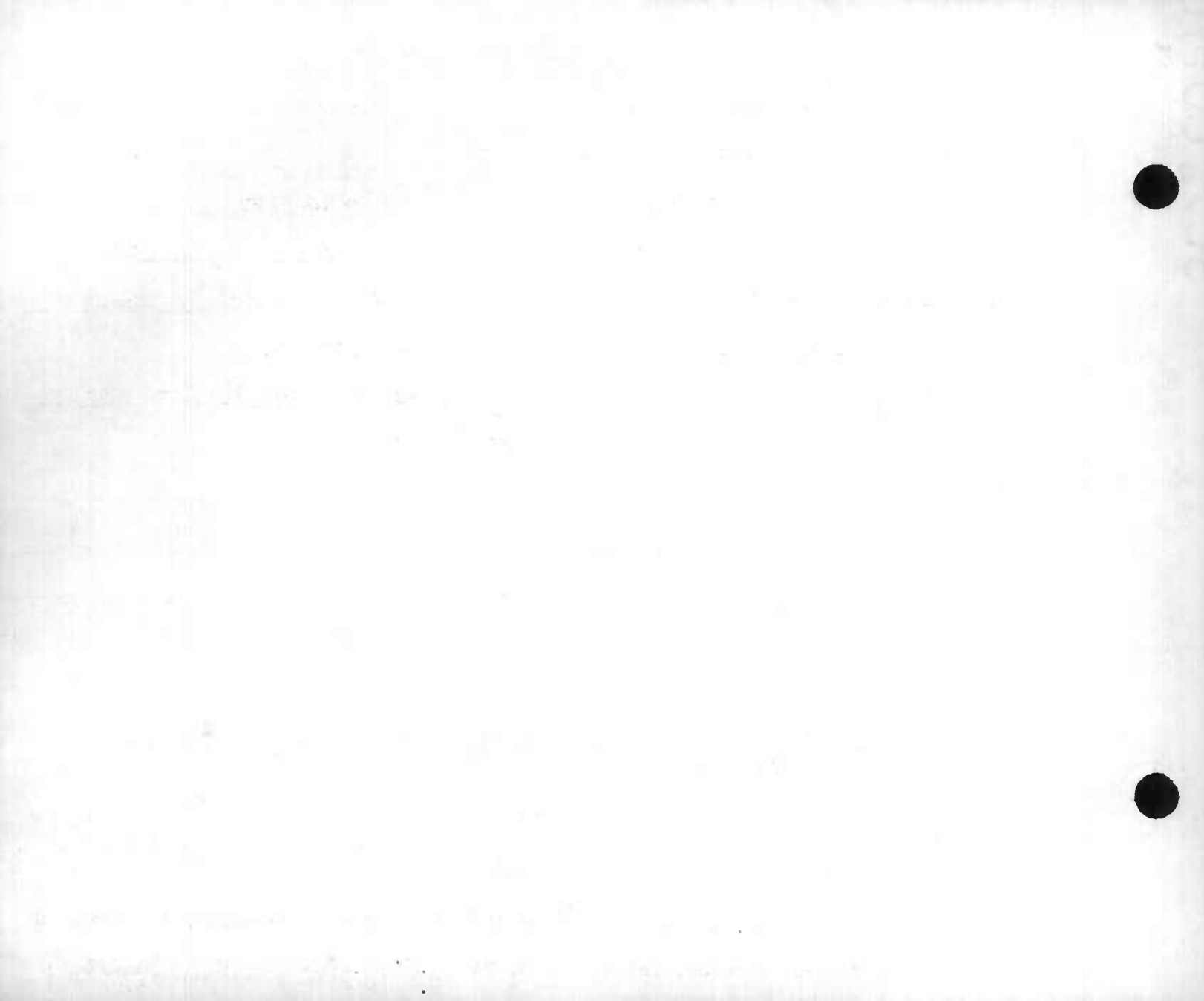
[Faint, illegible text at the bottom left corner]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 34051
REG. NO. | |
|--|--|---|--|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
JAY EDWARD KREBS | | | | | | DECEMBER 22 1984 | | | | 6:43 a.m. | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
DECEMBER 10 1984 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NORTH CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
N/A | | 12b. KIND OF BUSINESS OR INDUSTRY
N/A | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY
NORTH CAROLINA CRAVEN | | | | | | 13c. CITY OR TOWN
NEW BERN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
415 BOROS ROAD 28560 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
JEFFREY JAY KREBS | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
LINDA LOUISE HIGHT | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
N/A | | 17. INFORMANT ADDRESS
LINDA L. KREBS, 415 BOROS ROAD, NEW BERN, NC 28560 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO RESPIRATORY FAILURE | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (this hospital) attended the deceased from DECEMBER 10, 1984 to DECEMBER 22, 1984 , that (we) last saw the deceased alive on DECEMBER 22, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Susan M. Boisvert</i> | | | | DEGREE
MD | | | | 22c. DATE SIGNED
27 Dec 84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
S.M. BOISVERT, LT, MC, USNR | | | | 22e. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Removal | | | | 23b. DATE
Dec. 27, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Uniformed Services University of the Health Sciences | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Bethesda, MD | | | |
| 24. FUNERAL DIRECTOR
NAME
Capitol Funeral Service, Falls Church, VA | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Swinton Ruppelle</i> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Legibility is retained by the hospital or attending physician.

OK John Rogers, DME

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

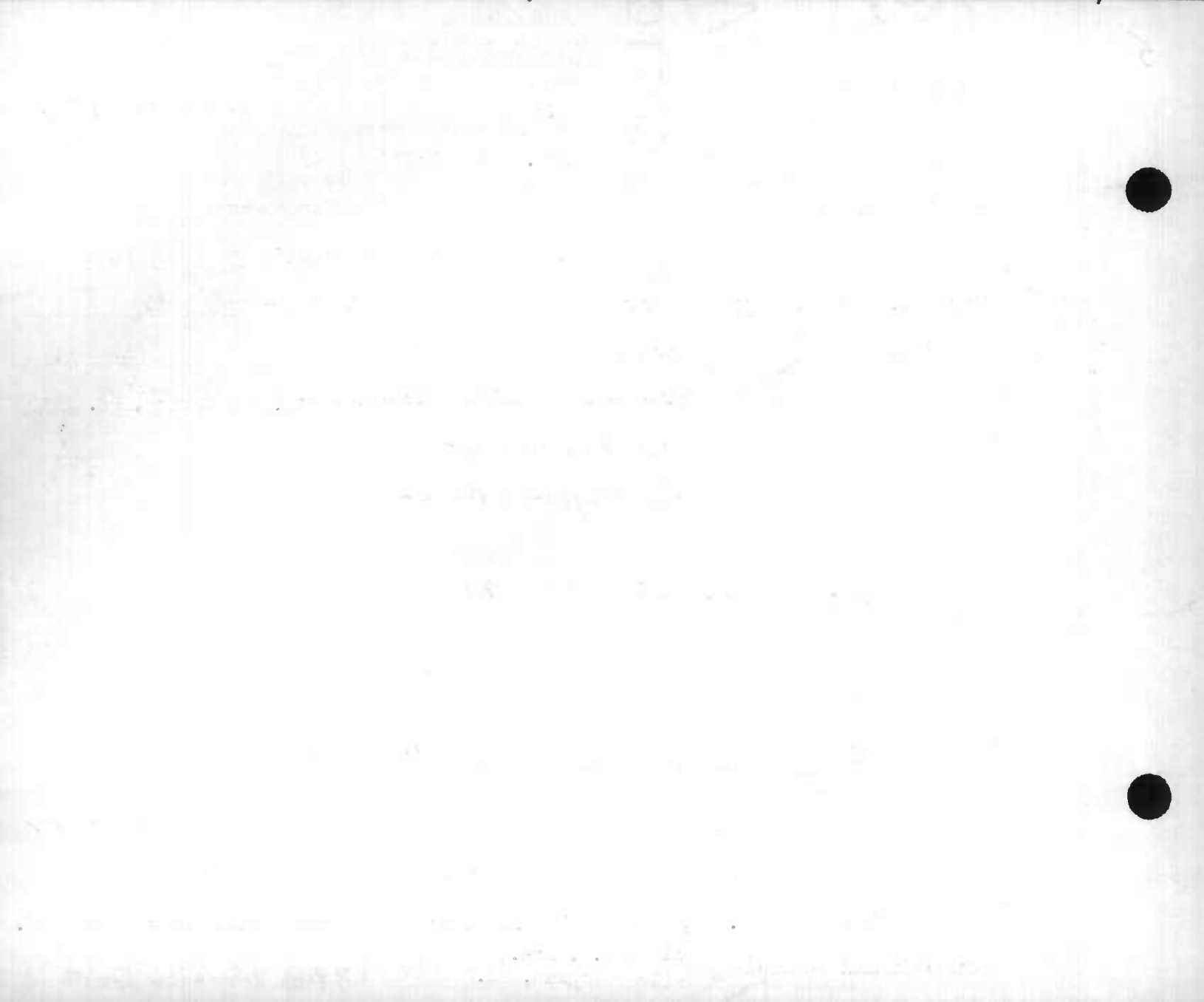
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | 3 4 0 5 2
REG. NO. | |
|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Betty Lou Kruhm | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-12-84 | | 2b. HOUR
1:00 P.M. |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan. 4 1935 | | 6. AGE (IN YEARS LAST BIRTHDAY)
49 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, DC | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sylvan Manor Health Care Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | 12b. KIND OF BUSINESS OR INDUSTRY
own home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Olney | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
301 Olney-Sandy Road 20832 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Franz Bergmann | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Dorothy Allen | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) N/A | | 16b. SOCIAL SECURITY NO.
N/A | 17. INFORMANT ADDRESS
Evelyn Maire-sister-Silver Spring, Md. 20904 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiac arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Huntington's chorea</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.
<u>Recurrent aspiration 2° X (b)</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>Nov 9</u> 19 <u>84</u> , to <u>Dec 12</u> 19 <u>84</u> , that (we) last saw the deceased alive on <u>Nov 9</u> 19 <u>84</u> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Barbara Blaylock, M.D.</u> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12-12-84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Barbara Blaylock, M.D. | | 22e. ADDRESS
6111 Executive Blvd, Rockville, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Dec. 14, 1984 | 23c. NAME OF CEMETERY OR CREMATORY
Union Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Burtonsville Montgomery Md. |
| 24. FUNERAL DIRECTOR
Hines/Rinaldi Funeral Home | | 11800 N.H. Ave.,
Silver Spring, Md. | | 25a. DATE REC'D. BY REGISTRAR
DEC 13 1984 | |
| 25b. REGISTRAR'S SIGNATURE
<u>Julia Anderson Randall</u> | | | | | |

MEDICAL CERTIFICATION

29

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

34053
REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|-------|
| 1. DECEASED NAME
(TYPE OR PRINT) EVELYN L KURCIAS | | | 2a. DATE OF DEATH
MONTH 12 DAY 18 YEAR 84 | | | 2b. HOUR
7 P M | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
Oct. 6, 1910 YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 | | 7. IF UNDER 1 YEAR
MONTHS 0 DAYS 0 HOURS 0 MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
IOWA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SUBURBAN HOSPITAL | | | | 12a. USUAL OCCUPATION
(GIVE WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 14. FATHER'S NAME
Hugh | | MIDDLE
LaGrange | | 15. MOTHER'S MAIDEN NAME
Leddie | | MIDDLE
Vestrum | | LAST | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | | 17. INFORMANT
Bernard Kurcias | | ADDRESS
same as #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intra cerebral hemorrhage | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) _____ | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET | | CITY OR TOWN | | STATE |
| 22a. I certify that xx (this hospital) attended the deceased from Dec 18 , 19 84 , to death , 19 _____, that (I) (we) last saw the deceased alive on Dec 18 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Barbara Blaylock, M.D. | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
12-19-84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Barbara Blaylock, M.D. | | | | | 22e. ADDRESS
6111 Executive Blvd., Rockville, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | 23b. DATE
12-19-84 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | | 23d. LOCATION
CITY OR TOWN Alexandria, COUNTY Va. STATE | | |
| 24. FUNERAL DIRECTOR
NAME Ives Pearson Funeral Homes
Arlington, Va. 22201 | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
John E. ... | | |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
20M 4-82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 34054

| | | | | | | | | | | | | | |
|--|--|------------------|--|---|--|--|---|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) RICHARD STANLEY KUSS | | | | | | | 2a. DATE KNOWN OF DEATH
XX 12-14 19 84 | | | 2b. HOUR
10 P.M. | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 19, 1931 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY) YRS.
53 | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
12-16 19 84 | | 2d. HOUR
2 P.M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Chevy Chase | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5500 Friendship Blvd., #1129N | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Auditor | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Gov't. Account Office | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Chevy Chase | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS (20817)
5500 Friendship Blvd., #1129N | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Herman Kuss | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Florence Diamond | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
Korean Conflict | | 17. INFORMANT
Silver Spring, Md. 20910 | | Mrs. Florence Wolfson; 8107 Eastern Ave. 514 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. }
(b) Coronary Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
Diabetes mellitus | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>John Tauber</i> | | | | TITLE (SPECIFY)
M.D. Deputy | | | | MEDICAL EXAMINER
DATE SIGNED 12-16-1984 | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
John Tauber | | | | ADDRESS
8218 Wisc., Ave., Bethesda, Md | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
12/19/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Quantico National Cemetery; Quantico, Virginia | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR
NAME
Danzansky-Goldberg Chapels; 1170 Rockville | | | | ADDRESS
Rockville, Md. | | | | 25a. DATE REC'D BY REGISTRAR
DEC 21 1984 | | | | 25b. REGISTRAR'S SIGNATURE
<i>John Tauber</i> | |

RECEIVED
JAN 10 1964
U.S. AIR FORCE

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
[illegible text follows]

RECEIVED

UNIT



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

FOR
STATE
REGISTRAR

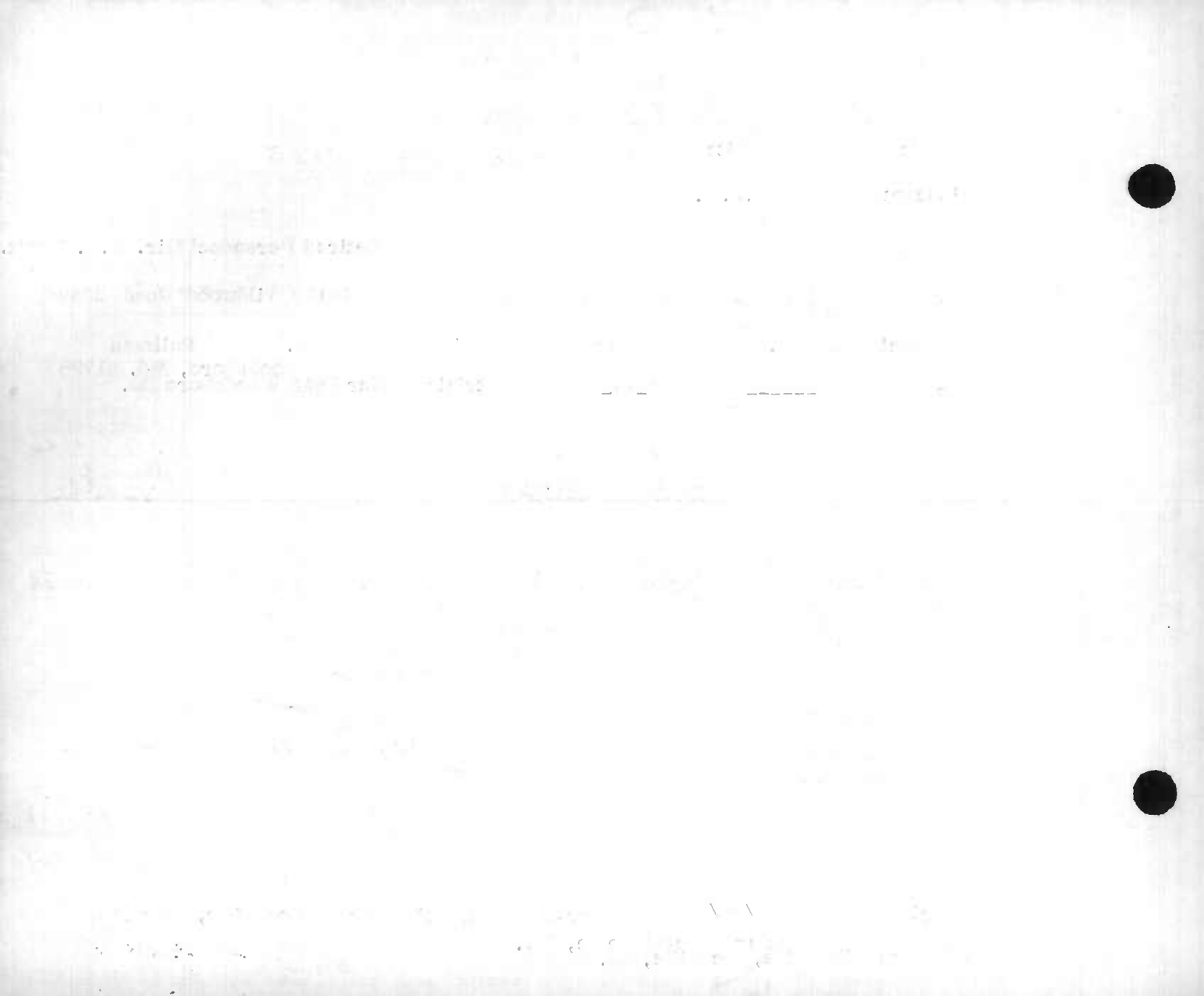
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

34055

| | | | | | | | | | |
|--|--|---|--|---|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Charles Earl Lamson | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-17-84 | | | 2b. HOUR
12²⁰ P.M. | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Nov 20 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
85 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Minnesota | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION
(NATURE OF WORK FOR MOST OF WORKING LIFE)
Retired Personnel | | 12b. KIND OF BUSINESS OR INDUSTRY
Dir. U.S. Gov't. | |
| 13a. STATE
Md | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Kensington | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET ADDRESS / ZIP CODE
10100 Wildwood Road 20895 | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Samuel E. Lamson | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Nina B. Pullman | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
213-44-7498 | | 17. INFORMANT
Woodboro, Md, 21798
Patricia Huffer 994B Woodboro Rd. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Kidney failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 years
many years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
Hypertension, aortic stenosis, congestive heart failure, Rheumatoid osteoarthritis | | | | | | | | | |
| 19a. DATE OF OPERATION
none related | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
 | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
none 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
none | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOLWHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
 | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
 | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 19, 1974 , to Dec 16 , 19 84 , that (I) (we) lost saw the deceased alive on Dec 16 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Allen J. O'Neill M.D. | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | 22c. DATE SIGNED
Dec 17, 1984 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Allen J. O'Neill, M.D. | | | 22e. ADDRESS
8601 Old Georgetown Rd. Bethesda Md | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
12/20/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Memorial Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville, Maryland | | |
| 24. FUNERAL DIRECTOR
Tyson Wheeler Funeral Home, Inc.
1331 Rockville Pike, Rockville, Md. 20852 | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 24 1984 | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, pages 1 and 2, and attach them to the certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 (show only injury) or other traumatic event, the funeral examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 3 4 0 5 6
REG. NO. | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MARY MIDDLE LAWRENCE LAST | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 13 84 | | 2b. HOUR
12 07 P M | | | |
| 3. SEX
F | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR
12- 27-1912 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Own-Home | | | |
| 13a. STATE
MD | | 13b. COUNTY
V | | 13c. CITY OR TOWN
Wash., D.C. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
520 Oglethorpe St., N.E. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Robert Posey | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Pauline Bell | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
578-12-5216 | | 17. INFORMANT
12901 Cloverly Dr.
Wanda L. Mayfield Upper Malboro, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Chronic Renal Failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
45 min.
5 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Anemia, States Post Paraneoplastic, Hypertension</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>October 19 84</u> to <u>13 Dec 84</u> , that (I) (we) last saw the deceased alive on <u>13 Dec 84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
James H. Knepp, MD | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
13 Dec 1984 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
James H. Knepp, MD | | 22e. ADDRESS
4905 DelRay Ave, Bethesda, Md 20014 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/18/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington, Va. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Alexander S. Pope 2617 Penn Ave S.E.
DEC 24 1984
JULIA DAVIDSON-ROBERTS | | | | | | | | | |

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100-100000-100

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 4 0 5 7
REG. NO.

| | | | | |
|--|------------------------------|---|---|---|
| 1- FOR
STATE
REGISTRAR | | 2a. DATE KNOWN
OF ESTI.
DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR | | 2b. HOUR |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | |
| Ngoc Van Le | | | | |
| 1. SEX | 4. RACE | 5. DATE OF BIRTH
MONTH DAY YEAR | 6. AGE (IN YEARS
LAST BIRTHDAY) | 7. IF UNDER 1 YR.
MONTHS DAYS |
| MALE | ORIENTAL | June 6 1943 | 41 YRS. | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 2c. DATE
PRONOUNCED
DEAD | |
| VIET NAM | VIET NAM | | 12 13 1984 | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) |
| GAITHERSBURG | | 19231 Montgomery Avenue | | MEDICAL LAB TECHNICIAN |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS |
| MARYLAND | MONTGOMERY | TAKOMA PARK | | 8702 GILBERT PLACE 20912 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | |
| RIEM VAN LE | | CHIEN THI TRAN | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT |
| NO | | 216-04-4813 | | 8452 BROKEN ARROW COURT
CHIEN LE ANNANDALE, VA. 22003 NEPHEW |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Blunt trauma to head</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR <u>6</u> :P.M. MONTH DAY YEAR
<u>12/12</u> <u>1984</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE
AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE |
| | | auto/passengerSide | | 19231 Montgomery Ave, Gaithersburg, MontCo, MD |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion
death resulted from: <u>Natural causes</u> <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | |
| ACTUAL
SIGNATURE | | TITLE (SPECIFY)
M.D. Assistant | | DATE
SIGNED |
| EXAMINER'S NAME
(TYPE OR PRINT) | | ADDRESS | | |
| Gregory R. Kauffman, M.D. | | 111 Penn Street, Balto, MD 21201 | | 12/13/84 |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY |
| BURIAL | | 12/15/84 | | GATE OF HEAVEN |
| 24. FUNERAL DIRECTOR
NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE |
| FRANCIS J. COLLINS | | DEC 19 1984 | | Jana Davidson-Bundale |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | |

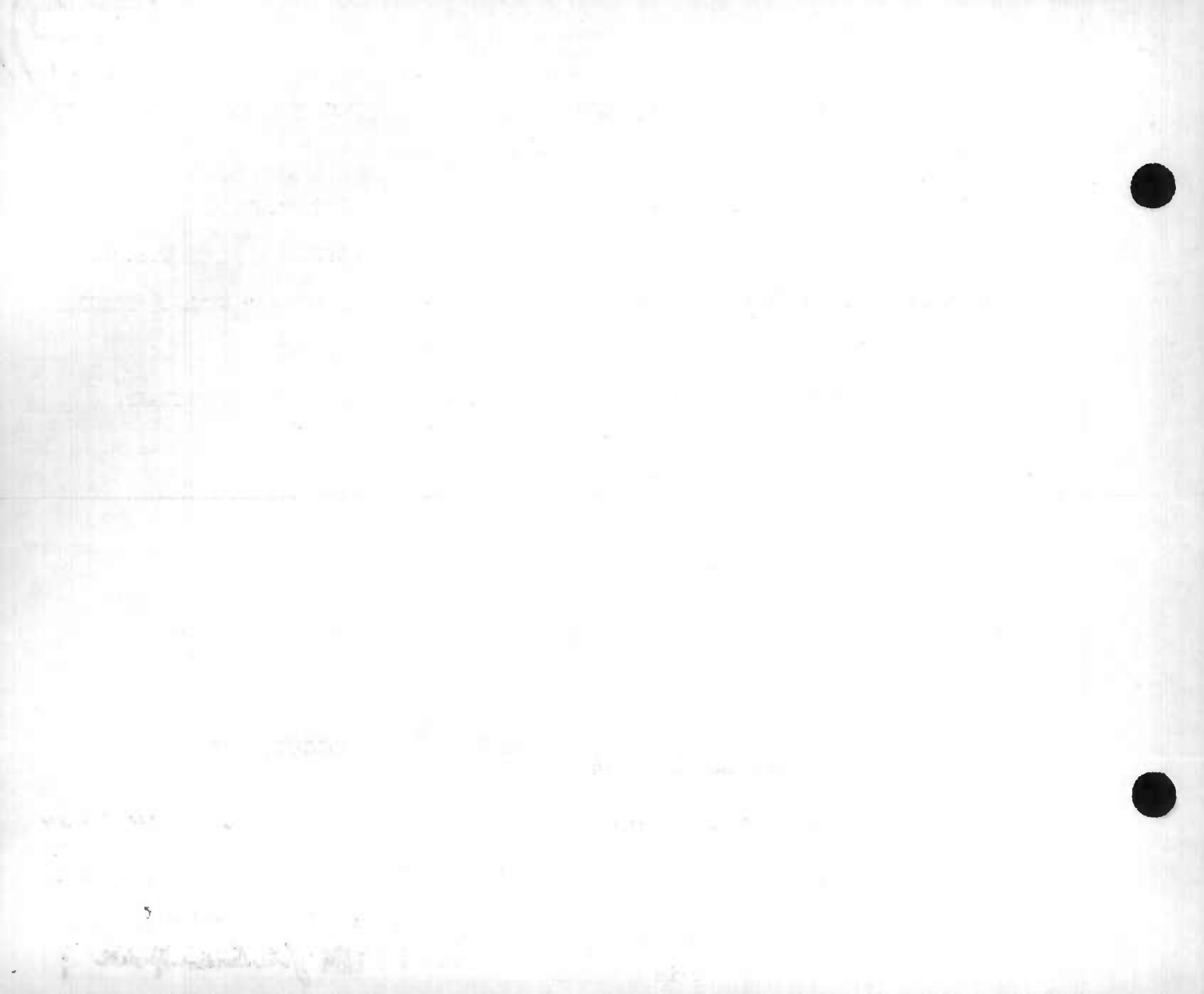
REBEL LOTION CO.

NEW YORK



1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 4 0 5 8
REG. NO.

| | | | | | |
|--|--|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
FRANCIS JOSEPH LESNICK | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 13 1984 | | 2b. HOUR
7:15 P |
| 3. SEX
MALE | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH DAY YEAR
SEPTEMBER 20 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. NAVY |
| 13a. STATE
VIRGINIA | | 13b. COUNTY
ARLINGTON | 13c. CITY OR TOWN
ARLINGTON | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
525 POLLARD STREET 22203 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
MATTHEW LESNICK | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ANNIE MARTINEZ | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
1917-1945 | 17. INFORMANT
ADDRESS
KATHLEEN LESNICK, 525 POLLARD STREET, | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ARLINGTON, VA 22203 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 9 , 19 84 , to DECEMBER 13 , 19 84 , that (I) (we) lost saw the deceased alive on DECEMBER 13 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Bruce L Flax MD | | DEGREE
PHYSICIAN | | 22c. DATE SIGNED
14 DEC 84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
B. L. FLAX, LT. MC, USNR | | 22e. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND,
NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
12/18/84 | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington, VA. | |
| 24. FUNERAL DIRECTOR'S NAME
Funphy Funeral Home 4510 Wilson Blvd. | | 25. DATE REC'D BY REGISTRAR'S SIGNATURE
DEC 19 1984 | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 34059

1. FOR
STATE
REGISTRAR

Lillian

| | | | | | |
|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Lillian Ruth Lettow | | | 2a. DATE OF DEATH
MONTH DAY YEAR
11-29-84 | | 2b. HOUR
12 P.M. |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
11 24 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY)
91 | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASHINGTON, D.C. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
TAKOMA PARK | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
WASHINGTON ADVENTIST HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SUPERVISOR | 12b. KIND OF BUSINESS OR INDUSTRY
G.S.A. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
MARYLAND | 13b. COUNTY
PRINCE GEORGES | 13c. CITY OR TOWN
MT. RAINIER | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
3216 CHILLUM ROAD 20712 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
GEORGE JEFFRIES | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ELIZA WILLIAMS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
577-60-3699 | | 17. INFORMANT
SISTER
KATHERINE M. KNICELY
ADDRESS
307 WAYNE PLACE
SILVER SPRING, MD. 20910 | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebrovascular Accident

DUE TO, OR AS A CONSEQUENCE OF

(b)

Aspiration Pneumonia

DUE TO, OR AS A CONSEQUENCE OF

(c)

Brain Stem Herniation

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

| | | | | | |
|--|--|--|--|--|---|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-25-1984 to 11-29-1984, that (I) (we) lost saw the deceased alive on 11-28-1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Tom P. Kannerkat | | DEGREE
M.D. | | 22c. DATE SIGNED
11/29/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Tony P. Kannerkat | | 22e. ADDRESS
8201 16th St S.S. MD 20910 | | | |

| | | | |
|--|----------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
12/3/84 | 23c. NAME OF CEMETERY OR CREMATORY
ARLINGTON NATIONAL | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ARLINGTON VIRGINIA |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS | | 25a. DATE REC'D. BY REGISTRAR
DEC 6 1984 | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | 25b. REGISTRAR'S SIGNATURE
John Darden | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXCLUDE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHAM - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 4 0 6 0

REG. NO.

| | | | | | | | |
|--|-------------------------|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 2. DECEASED NAME
FIRST MIDDLE LAST
HERBERT LEVY | | 7a. DATE KNOWN OF DEATH
MONTH DAY YEAR
12 12 84 | | 7b. HOUR OF ESTIMATED DEATH
HOUR MIN
8 45 | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 8, 1904 | 6. AGE (IN YEARS)
LAST BIRTHDAY
80 YRS. | IF UNDER 1 YR.
MONTHS DAYS
0 0 | IF UNDER 24 HRS.
HOURS MIN.
0 0 | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
12 12 84 | 7d. HOUR
HOUR MIN
8 45 |
| 7e. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, D.C. | | 7f. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | |
| 10. CITY OR TOWN OF DEATH
Chevy Chase | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3225 Pauline Drive | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Owner | | 12b. KIND OF BUSINESS OR INDUSTRY
Printing Shop | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | 13b. CITY OR TOWN
Montgomery | | 13c. CITY OR TOWN
Chevy Chase | |
| 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3225 Pauline Drive (20815) | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Levy | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sadie Haas | | ADDRESS Chase, Md. 20815 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
578-46-7306 | | 17. INFORMANT
Sylvia S. Levy; 3225 Pauline Drive; Chevy Chase, Md. 20815 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio Respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) Broncho pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c) multiple sclerosis | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE
John Tauber | | TITLE (SPECIFY)
Deputy | | MEDICAL EXAMINER
Bethesda Md. | | DATE SIGNED
12-12-84 | |
| EXAMINER'S NAME
(TYPE OR PRINT)
John Tauber | | ADDRESS
8218 Wisconsin Ave | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
SPECIFY
Burial | | 23b. DATE
12/13/84 | | 23c. NAME OF CEMETERY OR CREMATORY
King David Mem. Garden | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Falls Church; Fairfax; Va. | |
| 24. FUNERAL DIRECTOR
NAME
DANZANSKY-GOLDBERG MEMORIAL CHAPELS | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 18 1984 | | | |
| 1170 Rockville Pike; Rockville, Md. 20852 | | | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Hordale | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

34061

FOR
1 - STATE
REGISTRAR

| | | | | | | | | | |
|--|--|---|--|---|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) houis E levy | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-19-84 | | | 2b. HOUR
1:10 PM | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Sep. 28, 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY)
88 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Wash., D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery - MD. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Owner (Ret) | | 12b. KIND OF BUSINESS OR INDUSTRY
Liquor Store | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Harris | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rose Edelson | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes WW I | | | |
| 16b. SOCIAL SECURITY NO.
589-44-7277 | | | 17. INFORMANT
Bethesda, Md. 20817 | | | 17. INFORMANT
Bernice Leonard; 6002 Pelham Pl. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebro-vascular accident
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerosis
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
Smoking | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 21g. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1980 to late 1984
saw the deceased alive on 12/19/84 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
MD | | | 22c. DEGREE
MD | | | 22d. ATTENDING PHYSICIAN
<input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22e. DATE SIGNED
12/19/84 | |
| 22f. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. G. WARD | | | 22g. ADDRESS
6116 ROBINWOOD, BETHESDA, MD | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
12-21-1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Keshet Israel Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D.C. | | |
| 24. FUNERAL DIRECTOR
NAME
Danzansky-Goldberg Chapels; | | | 24. FUNERAL DIRECTOR
ADDRESS
1170 Rockville Pike | | | 25a. DATE REC'D. BY REGISTRAR
2-4-1985 | | 25b. REGISTRAR'S SIGNATURE
John Davidson | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

| FOR
STATE
REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 3 4 0 6 2
REG. NO. | | | |
|--|--|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Jules Libman | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 03 84 | | | | 2b. HOUR
3:05AM | | | |
| 3 SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 22, 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Printer (Ret.) | | 12b. KIND OF BUSINESS OR INDUSTRY
GPO | | | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
14643 Bauer Drive 20853 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
David Libman | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sarah Selvin | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | 16b. SOCIAL SECURITY NO.
059-09-3021 | | 17. INFORMANT 9 Wandering Trail Court
Gerald Libman; Potomac, Md. 20854 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) Arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) Chronic ulcerative colitis | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 hours
3 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Chronic ulcerative colitis | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/3 , 19 80 , to 12/3 , 19 84 , that (I) (we) last saw the deceased alive on 12/3 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN G. LODWELL, MD | | | | DEGREE MD
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12/3/84 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
12-4-1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Lebanon Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Hyattsville, Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME
Danzansky-Goldberg | | | | CITY OR TOWN
Rockville, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 4 1984 | | | |
| 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | | | | | | | | |

BP

MAR 01:2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 34063 | | | | | |
|---|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
<i>Eugene GROVER Linck</i> | | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>12-17-84</i> | | | | 2b. HOUR
<i>5:00 A.M.</i> | |
| 3. SEX
<i>male</i> | | 4. RACE
<i>white</i> | | 5. DATE OF BIRTH MONTH DAY YEAR
<i>5-26-22</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>62</i> YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>New Jersey</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>MONTGOMERY</i> MD. | | | |
| 10. CITY OR TOWN WHERE DECEASED
<i>SILVER SPRING</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>HOLY CROSS HOSPITAL</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>AUDITOR</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>A.I.D.</i> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE <i>MARYLAND</i> 13b. COUNTY <i>MONTGOMERY</i> 13c. CITY OR TOWN <i>WHEATON</i> | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
<i>12911 HOLDRIDGE ROAD 20906</i> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<i>HAROLD T. LINCK</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<i>MARIE HARBULA</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
<i>YES</i> | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
<i>UNW II 138-16-2353</i> | | 17. INFORMANT
<i>VIOLET JEAN LINCK</i> | | | | ADDRESS
<i>SAME AS 13 WIFE</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Bacterial Sepsis</i>
DUE TO, OR AS A CONSEQUENCE OF, (b) <i>Pneumonia, Bronchial</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
DUE TO, OR AS A CONSEQUENCE OF, (c) <i>Squamous Carcinoma of Lung</i> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>1 day</i>
<i>2 days</i>
<i>few mos</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Diabetes Mellitus</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<i>7/31 1984</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>7/31</i> 19 <i>84</i> , to <i>12/17</i> 19 <i>84</i> , that (I) (we) saw the deceased alive on <i>12/16</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <i>(did)</i> view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>G. Lennard Gold</i> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
<i>12/17/84</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>G. LENNARD GOLD</i> | | | | 22e. ADDRESS
<i>SILVER SPRING, MARYLAND</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>CREMATION</i> | | 23b. DATE
<i>12/18/84</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>METROPOLITAN CREMATORY</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE
<i>ALEXANDRIA VIRGINIA</i> | | | |
| 24. FUNERAL DIRECTOR <i>FRANCIS J. COLLINS</i>
NAME
<i>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>DEC 19 1984</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | | |

THE UNIVERSITY OF CHICAGO
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical section, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for autopsy.

DHMH - 16 60M 7/B4
(VRA 15, 4)

| FOR
1 - STATE
REGISTRAR | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | REG. NO. 34064 | |
|---|--|---|---|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) MARGUERITE G. Lindstrom | | 2a DATE OF DEATH MONTH DAY YEAR 12 16 84 | | 2b HOUR 10 10 AM | |
| 3. SEX Female | 4. RACE CAUC | 5. DATE OF BIRTH MONTH DAY YEAR 08 15 97 | | 6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) CHICAGO, ILL. | 7b CITIZEN OF WHAT COUNTRY? USA | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 10 CITY OR TOWN OF DEATH Rockville | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Center | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b KIND OF BUSINESS OR INDUSTRY - |
| 13a STATE Md. | | 13b COUNTY Montgomery | 13c CITY OR TOWN Gaithersburg | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS / ZIP CODE 769 Tiffany Drive 20878 |
| 14 FATHER'S NAME FIRST MIDDLE LAST Jacob L. Siegenthaler | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie Anna Griebahn | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | |
| 16b SOCIAL SECURITY NO. 349-07-9520A | | 17 INFORMANT (Son) David L. Hansen | | 18 ADDRESS 769 Tiffany Drive, Gaithersburg, Md. 20878 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular arrhythmia DUE TO, OR AS A CONSEQUENCE OF (b) hypertension DUE TO, OR AS A CONSEQUENCE OF (c) diabetes | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden
years |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: diabetes | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NO <input type="checkbox"/> WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from 6/24 19 84 to 12/16 19 84 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on 12/16 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE John R. Melnick | | DEGREE MD | | 22c DATE SIGNED 12/16/84 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) John R. Melnick | | 22e ADDRESS 16220 Freerich Rd - Gaithersburg, Md 20877 | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b DATE 12/19/84 | | 23c NAME OF CEMETERY OR CREMATORY Mount Emblem Cemetery | |
| 23d LOCATION CITY OR TOWN Elmhurst | | COUNTY DuPage | | STATE Ill. | |
| 24 FUNERAL DIRECTION NAME Garthner Sandison F.H. | | ADDRESS 316 E. Diamond Ave., Gaithersburg, Md. 20877 | | DEC 24 1984 John Sandison | |

#10R FilmG600 2/8/85 kam

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 34065

1- STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Bertha Lockhart

2a. DATE KNOWN OF DEATH ☒ MONTH DAY YEAR
12 17 1984

2b. HOUR 0903

3. SEX Female

4. RACE White

5. DATE OF BIRTH MONTH DAY YEAR
June 12, 1886

6. AGE (IN YEARS LAST BIRTHDAY) 98 YRS.

IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

7c. DATE PRONOUNCED DEAD 12 17 1984

7d. HOUR 0903

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.

10. CITY OR TOWN OF DEATH Bethesda

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Naval Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker

12b. KIND OF BUSINESS OR INDUSTRY Home

13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE DC 13b. COUNTY None 13c. CITY OR TOWN Washington

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS 4410 42nd St. NW 20016

14. FATHER'S NAME FIRST MIDDLE LAST
Wilbert Thomas Maxwell

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Bertha Dana

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No

16b. SOCIAL SECURITY NO. 579-70-7805

17. INFORMANT ADDRESS
Bertha L. Clark Same as item # 13

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO PULMONARY FAILURE
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) FRACTURED HIP
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ACUTE
17 DAYS

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
HIP NAILING NONE

19a. DATE OF OPERATION 12/13/84

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? HIP NAILING

19c. AUTOPSY? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 12 1 1984

20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) FELL DOWN STEPS

21a. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME

21c. LOCATION STREET CITY OR TOWN COUNTY STATE
4410 42nd St WASHINGTON DC

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE Francis C. Mayle, M.D. TITLE (SPECIFY) DEPT. MEDICAL EXAMINER

DATE SIGNED Dec. 18, '84

EXAMINER'S NAME (TYPE OR PRINT) Francis C. Mayle, M.D. ADDRESS 8200 WI Ave. Beth., MD 20814

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation

23b. DATE 12/19/84

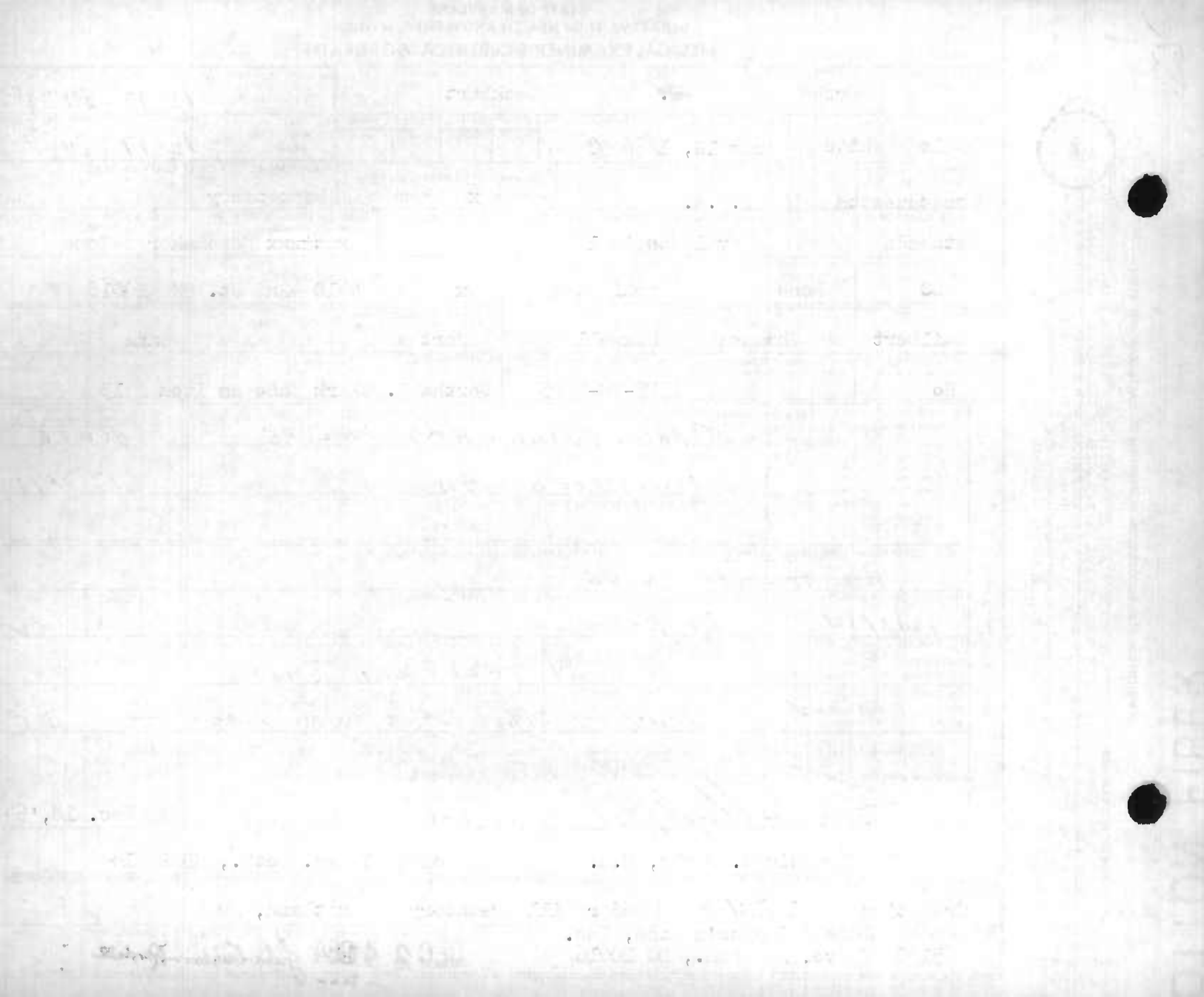
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory

23d. LOCATION CITY OR TOWN COUNTY STATE
Suitland, MD

24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. NAME ADDRESS 5130 WI Ave, NW Wash., DC 20016

25a. DATE REC'D. BY REGISTRAR DEC 24 1984

25b. REGISTRAR'S SIGNATURE John Davidson-Rodette



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

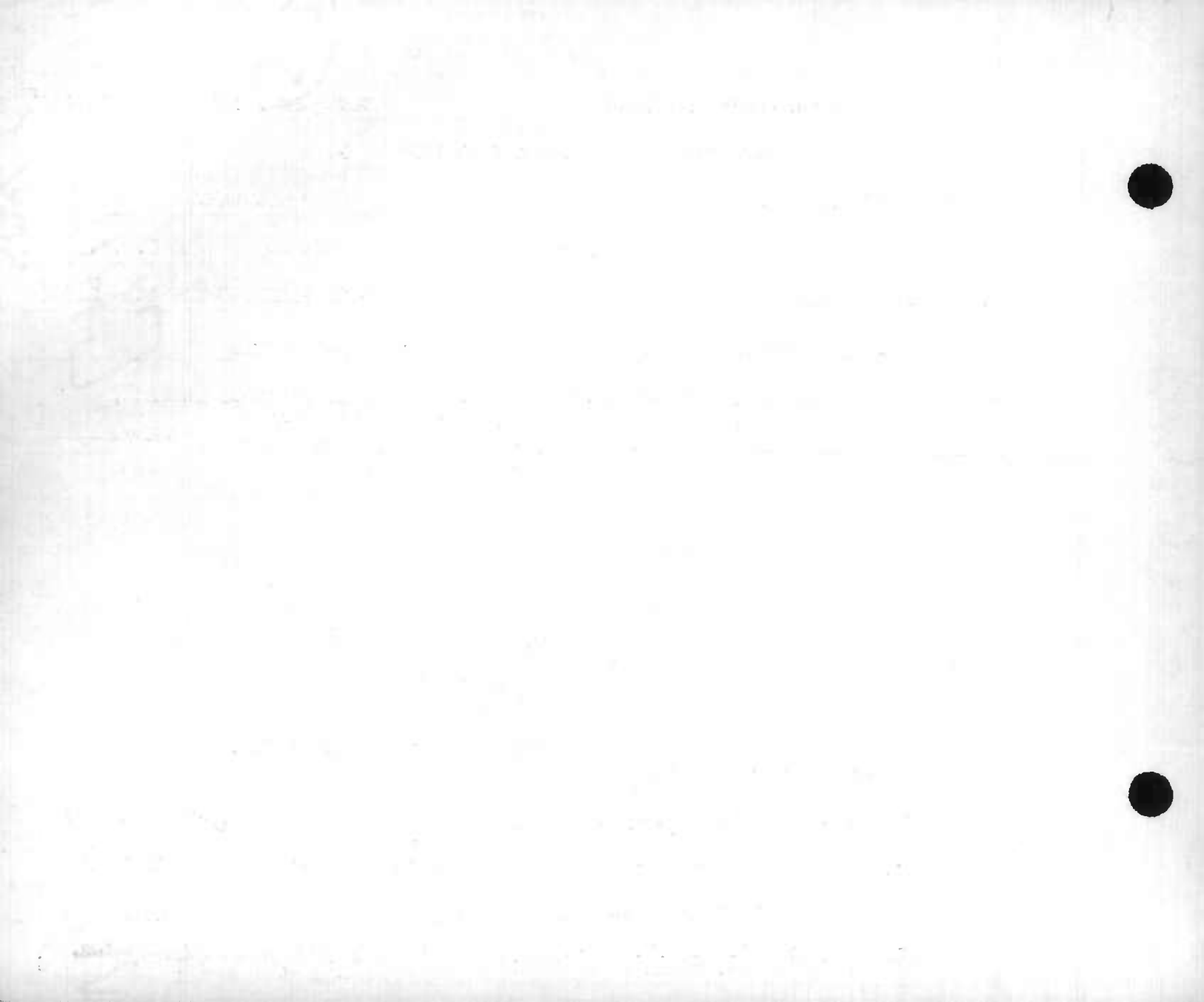
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

34066
REG. NO.

| | | | | | |
|--|---|--|---------------------------------|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | a m | |
| PAUL EDWARD LOCKWOOD | | DECEMBER 7 1984 | | 12:10 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YEAR | |
| MALE | CAUCASIAN | FEBRUARY 20 1930 | 54 | MONTHS DAYS HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 9. BALTIMORE CITY OR COUNTY OF DEATH | 10. CITY OR TOWN OF DEATH | | | |
| WEST VIRGINIA | MONTGOMERY | BETHESDA | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| NAVAL HOSPITAL | RETIRED | U.S.A.F. | | | |
| 13a. STATE | 13b. CITY OR TOWN | 13c. INSIDE CITY LIMITS? | 13d. STREET ADDRESS / ZIP CODE | | |
| VIRGINIA | FAIRFAX | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | FALLS CHURCH, VA 22042 | | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | |
| CHARLES EDWARD LOCKWOOD | ESTELLE JANE CHAFIN | YES | | | |
| 16b. SOCIAL SECURITY NO. | 17. INFORMANT | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | |
| 236-46-5339 | RITA LOCKWOOD, 3229 PARKWOOD TERRACE, | FALLS CHURCH, VA 22042 | | | |
| 19. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| | | HOUR A.M. MONTH DAY YEAR | | | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>OCTOBER 10</u> , 19 <u>84</u> , to <u>DECEMBER 7</u> , 19 <u>84</u> that (I) (we) lost | | | | | |
| saw the deceased alive on <u>DECEMBER 7</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | |
| above, (I) (we) did (did not) view the body after death. | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22c. DATE SIGNED | | 22d. ADDRESS | |
| W. A. DELACEY, LT, MC, USNR | | 7 Dec 84 | | NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 12-11-84 | | Arlington Nat'l Cem. | |
| 24. FUNERAL DIRECTOR | | 24a. DATE REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | |
| Money & King Vienna F.H. Inc. 171 W. Maple Ave. Vienna, VA 22180 | | DEC 11 1984 | | John Davidson-Randall | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

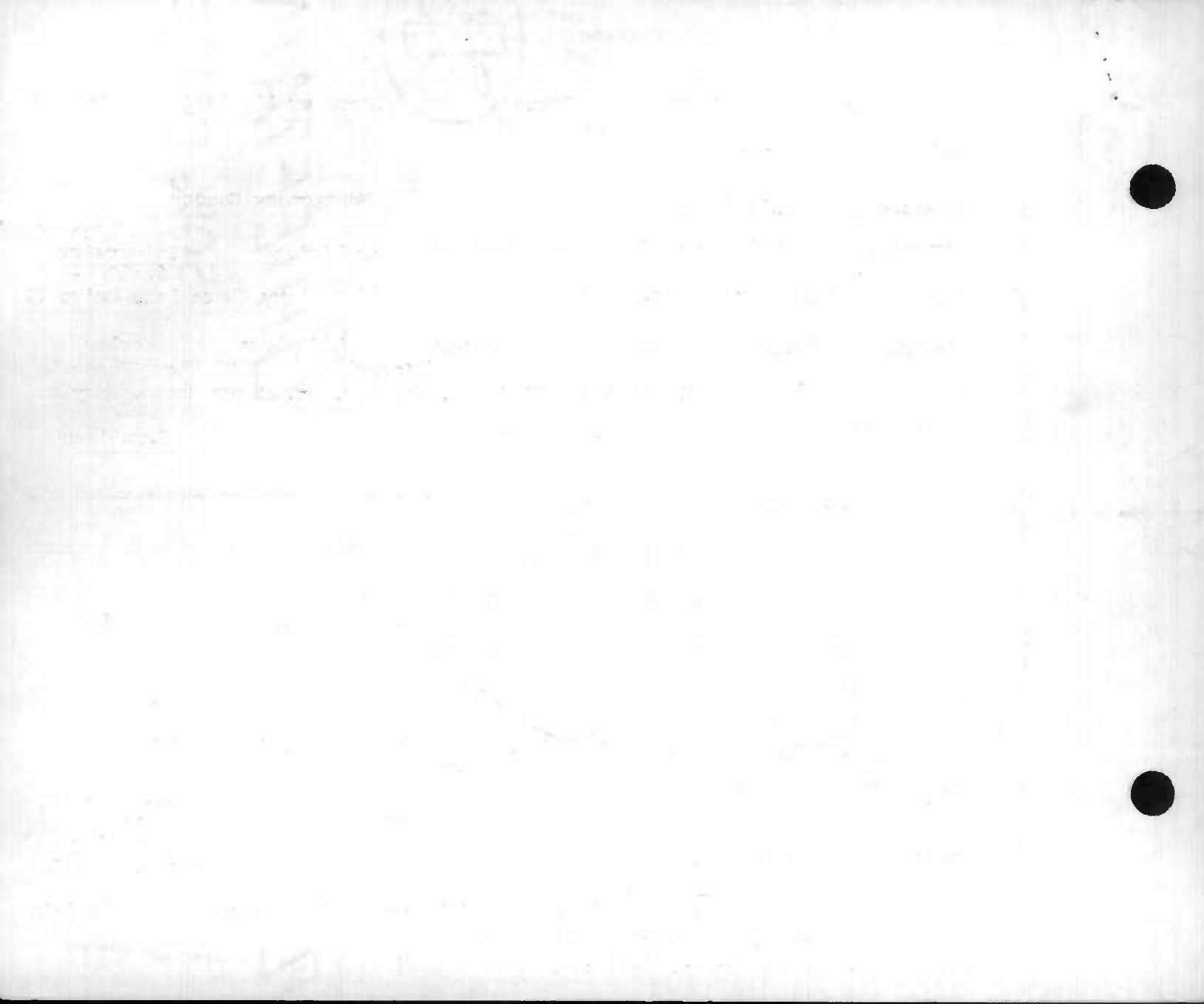
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Released By Medical Examiner's Office Per Dr. Rogers

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 34067 | |
|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Marion (NMI) Logue | | | | | | December 11, 1984 | | | | 1530 M | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
March 1, 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Tennessee | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Chevy Chase | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3603 Chevy Chase Lake Drive #1 | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Archivist | | 12b. KIND OF BUSINESS OR INDUSTRY
Education/
University
Zip: 20815 | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE
Maryland | | 13c. COUNTY
Montgomery | | 13d. CITY OR TOWN
Chevy Chase | | 13e. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13f. STREET ADDRESS / ZIP CODE
3603 Chevy Chase Lake Drive #1 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Samuel Rutledge Logue | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Coral Elizabeth Worley | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | | 17. INFORMANT (Sister)
Vivian L. Seymour, Dr. Chevy Chase, Maryland | | ADDRESS
3603 Chevy Chase Lake | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Embolism
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Immediate | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) examined attended the deceased from May 17, 1978, to Dec. 11, 1984, that (I) was last saw the deceased alive on Dec. 4, 1984, and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Jerry Allison Snow</i> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
December 12, 1984 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Jerry Allison Snow, M.D. | | | | 22e. ADDRESS
4900 Massachusetts Avenue, N.W. Washington, D.C. 20016 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
December 14, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
National Memorial Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Falls Church Virginia | | | | | |
| 24. FUNERAL DIRECTOR
NAME Robert A. Pumphrey Funeral Homes,
P.A. 7557 Wisconsin Avenue, Bethesda, MD | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 17 1984 | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson</i> | | | | | |



TO FURNISH DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 34068 | | | |
|---|--|--|--|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Terrence Thomas Long, Sr. | | | | | | December 9, 1984 | | | | | | 7:45PM | |
| 3. SEX
Male | | | 4. RACE
Caucasian | | | 5. DATE OF BIRTH MONTH DAY YEAR
October 5, 1922 | | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
62 | | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
10500 Rockville Pike | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Systems Technician Telephone Apt. #406 | | | 12b. KIND OF BUSINESS OR INDUSTRY (AT & T) | | | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | | 13c. CITY OR TOWN
Rockville | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE
10500 Rockville Pike / 20852 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Harry Joseph Long | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Margaret Louise Sprinkle | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
WWII | | 17. INFORMANT ADDRESS
Mrs. Jean C. Long, Wife, Same as item #13 | | | | | |
| MEDICAL CERTIFICATION
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Metastatic adenocarcinoma</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>gastric adenocarcinoma</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>arteriosclerotic heart disease</u> | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1973 to 12-9-84, that (I) (we) lost above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Donald L. Bucy | | | | | | | | 22c. DATE SIGNED
Dec. 10, 1984 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Donald L. Bucy, M.D. | | | |
| 22e. ADDRESS
809 Viers Mill Rd. Rockville, Md 20851 | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
December 12, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Silver Spring, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME
Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 13 1984 | | | | | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

34069

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
MABEL E. Loveland | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/04/84 | | | 2b. HOUR
2 PM | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 09 99 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Collinswood Nursing Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY
School | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William H. Stock | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elizabeth E. Fogel | | | 13e. STREET ADDRESS / ZIP CODE
1282 Bartonshire Way 20854 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
091-24-8201 | | 17. INFORMANT
ADDRESS
Elizabeth L. Bliss (same as 13e) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cerebrovascular thrombosis</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 Sept 84 | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>8 Oct 84</u> to <u>4 Dec 84</u> , that (I) (we) saw the deceased alive on <u>26 Nov 84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Walter E. Gooch MD</u>
DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | 22c. DATE SIGNED
4 Dec 84 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
WALTER E. GOOCH MD | | | | | 22e. ADDRESS
2309 SHOREFIELD RD WHEATON MD 20902 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | | 23b. DATE
Dec. 5, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria Fairfax Virginia | | |
| 24. FUNERAL DIRECTOR
NAME Robert A. Pumphrey
ADDRESS 7557 Wisconsin Ave., Bethesda, Maryland 20814 | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 7 1984 | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson</u> | | | |

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

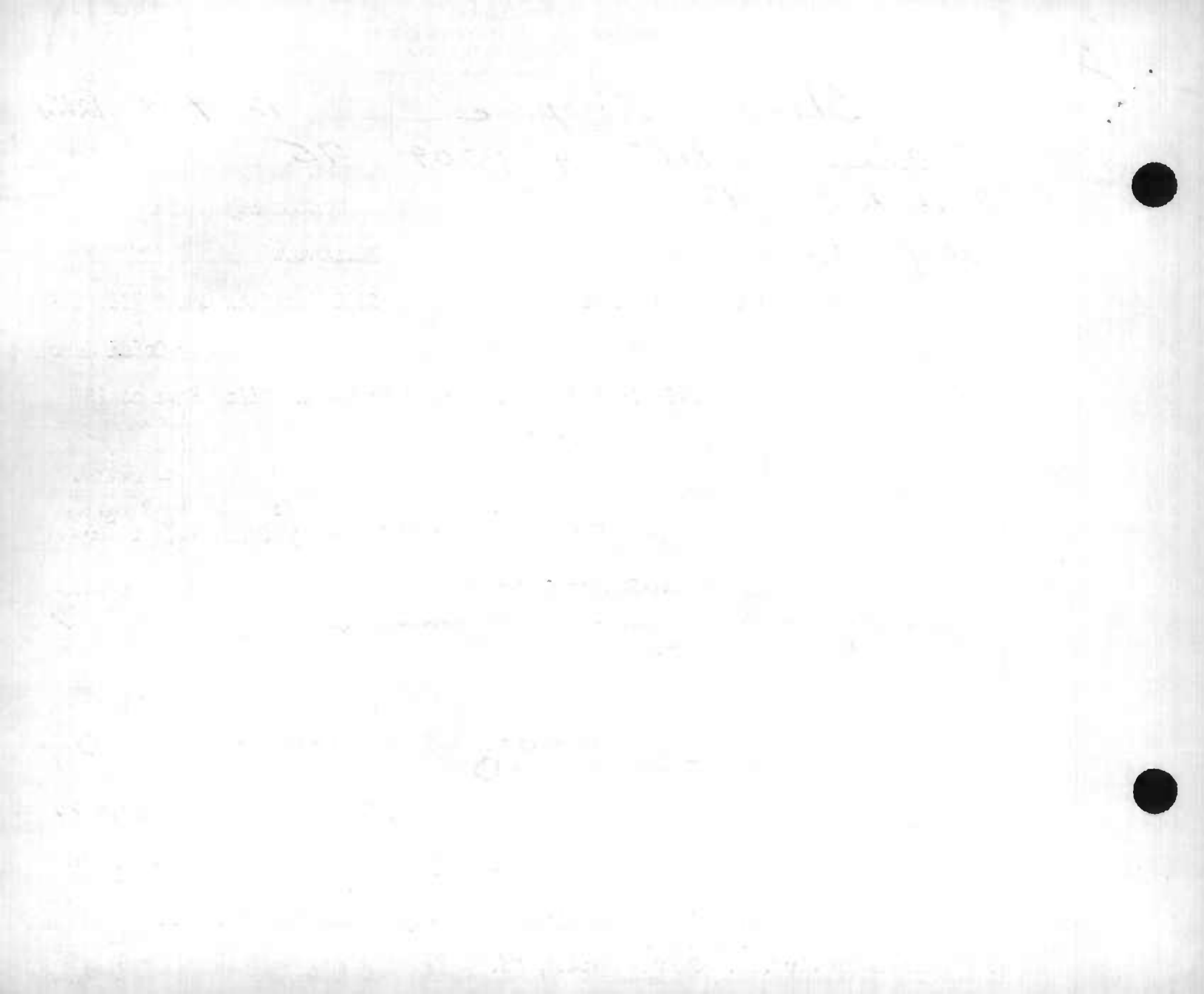
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

34070
REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|---|---|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <u>Thomas Lozupone</u> | | | 2a. DATE OF DEATH
MONTH <u>12</u> DAY <u>19</u> YEAR <u>84</u> | | | 2b. HOUR
<u>12:00 AM</u> | | | | | |
| 3. SEX
<u>Male</u> | | 4. RACE
<u>White</u> | | 5. DATE OF BIRTH
MONTH <u>4</u> DAY <u>15</u> YEAR <u>09</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>75</u> YRS. | | 7. IF UNDER 1 YEAR
MONTHS <u>0</u> DAYS <u>0</u> | | 8. IF UNDER 24 HRS
HOURS <u>0</u> MIN. <u>0</u> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>Wash. D.C.</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>US</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Montgomery</u> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
<u>Maryland</u> | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Holy Cross Hospital</u> | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Plasterer</u> | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
<u>Maryland</u> | | | 13b. COUNTY
<u>Montgomery</u> | | 13c. CITY OR TOWN
<u>Silver Spring</u> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<u>3602 Peartree Court #22 20906</u> | | |
| 14. FATHER'S NAME
FIRST <u>Stephano</u> MIDDLE <u>Lozupone</u> LAST <u>Lozupone</u> | | | 15. MOTHER'S MAIDEN NAME
FIRST <u>Maria</u> MIDDLE <u>Colachicco</u> LAST <u>Colachicco</u> | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) <u>Yes</u> | | | 16b. SOCIAL SECURITY NO.
<u>WW II</u> | | 17. INFORMANT
ADDRESS
<u>Mabel Louise Lozupone Wife Same as 13</u> | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>surgery for brain tumor, asphyxiation, pneumonia</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>2 weeks</u>
<u>3 weeks</u>
<u>2 weeks</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Diabetes Mellitus</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<u>11/29/84</u> | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>Brain tumor</u> | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/28/84</u> , 19 <u>84</u> , to <u>12/19/84</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>12/18/84</u> , 19 <u>84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Deborah B. Goldberg</u> | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
<u>12/19/84</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Deborah B. Goldberg</u> | | | 22e. ADDRESS
<u>1106 Spring St, Silver Spring Md.</u> | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | | 23b. DATE
<u>Dec. 22, 1984</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Fort Lincoln Cemetery</u> | | 23d. LOCATION
CITY OR TOWN <u>Brentwood Pr. Geo.</u> COUNTY <u>Md</u> STATE <u>Md</u> | | | | |
| 24. FUNERAL DIRECTOR
NAME <u>Francis J. Collins</u> ADDRESS <u>500 University Blvd., W. Silver Spring, Md.</u> | | | 25a. DATE REC'D. BY REGISTRAR
<u>DEC 24 1984</u> | | | 25b. REGISTRAR'S SIGNATURE
<u>John Davidson</u> | | | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

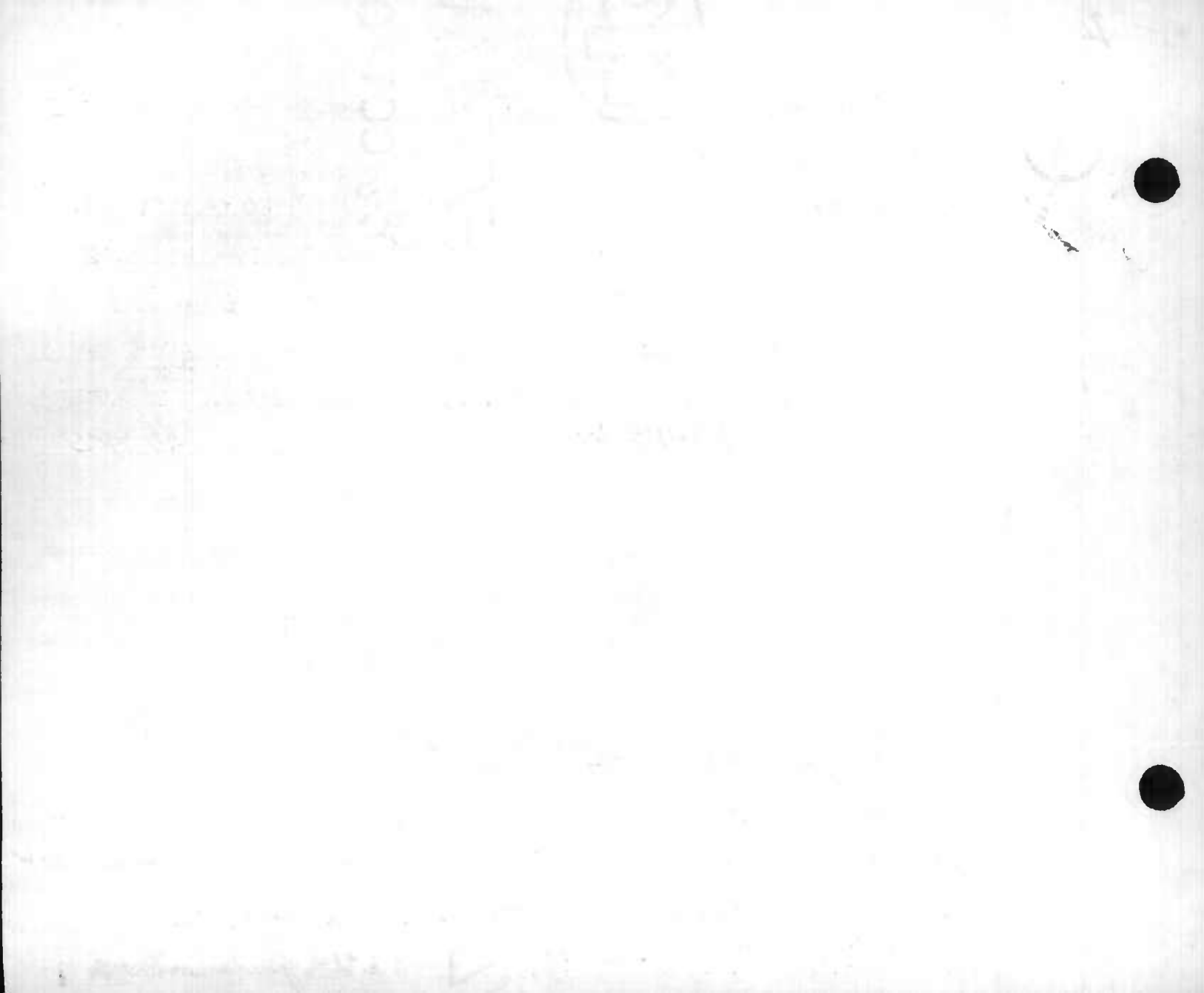
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | |
|---|--|--|--|
| 1. FOR
STATE
REGISTRAR | | 3 4 0 7 1 | |
| 1. DECEASED NAME
(TYPE OR PRINT)
Clara K. Lust | | 2a. DATE OF DEATH MONTH DAY YEAR
December 24, 1984 | |
| 3. SEX
Female | | 2b. HOUR
3:30 P.M. | |
| 4. RACE
Cauc | | 6. AGE (IN YEARS LAST BIRTHDAY)
88 YRS. | |
| 5. DATE OF BIRTH
MONTH DAY YEAR
12-13-1896 | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York, NY | | 7b. CITIZEN OF WHAT COUNTRY?
USA | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery Cty. MD. | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Collingswood Nursing Center | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY
HOME | |
| 13a. STATE
MD | | 13b. COUNTY
MONTG. | |
| 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
3715 Fitch Ave S.S. MD | | 20910 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOSEPH --- KLEIN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
REGINA --- (UNKNOWN) | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
577-50-3441 | |
| 17. INFORMANT
ADDRESS # 4 MONROE ST. | | MRS. DIDIE LUST - DAUGHTER ROCKVILLE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Lymphoma | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
20 YRS | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) _____ | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/23, 1981, to 12/24, 1984, that (I) (we) lost
saw the deceased alive on 12/24, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Walter E. Goode MD | | 22c. DATE SIGNED
12/24/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
WALTER E. GOODE MD | | 22e. ADDRESS
2309 SHOREFIELD RD WHEATON MD | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
12-26-84 | |
| 23c. NAME OF CEMETERY OR CREMATORY
MT. LEBANON CEM. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ADELPHI, MD. | |
| 24. FUNERAL DIRECTOR
DANZANSKY-GOLDBERG MEM CHP INC.
1170 ROCKVILLE PK. ROCKVILLE MD. | | 25a. DATE REC'D. BY REGISTRAR
DEC 31 1984 | |
| 25b. REGISTRAR'S SIGNATURE
John T. ... | | | |

BP



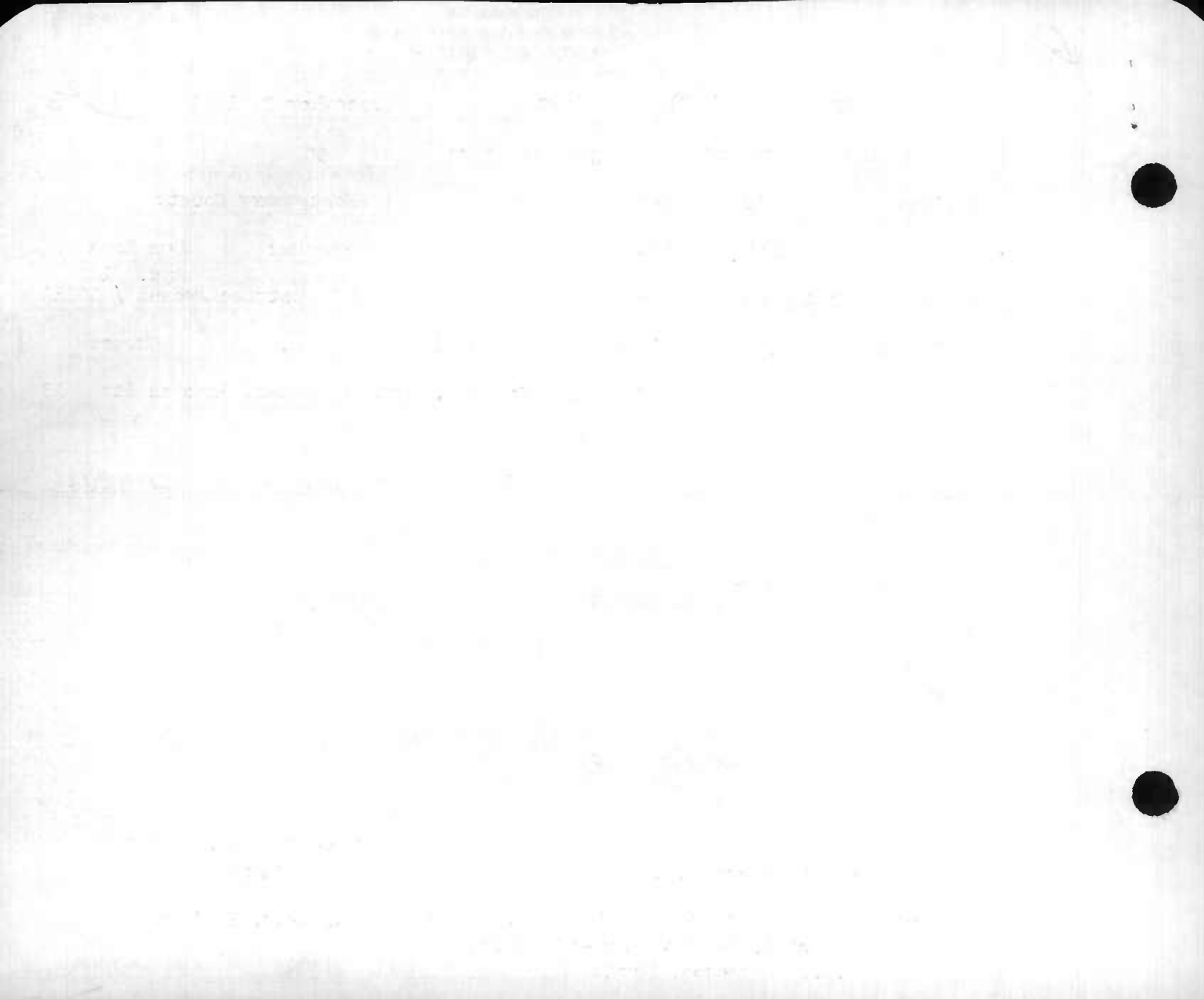
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH34072
REG. NO.1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Fern (NMI) Lust | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 3, 1984 | | | 2b. HOUR
1:00 P M | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 29, 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Indiana | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
10631 Montrose Avenue | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
Apt. #103
10631 Montrose Avenue / 20814 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William H. Miller | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Caroline A. Crouse | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
306-26-3235 | | 17. INFORMANT
ADDRESS
Miriam E. Lust, Daughter, Same as item #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) ARTERIO SCLEROTIC HEART DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) 2 year | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Pneumonia | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from AUGUST 19 79 to Dec 3 1984 , that (I) (we) lost
saw the deceased alive on Nov 15 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Robert V. Choisser M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12/3/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert Choisser, M.D. | | | | 22e. ADDRESS
5530 Wisconsin Avenue, #1240
Chevy Chase, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
December 8, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Fairhaven Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Mulberry, Indiana | | | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey Funeral Homes,
P.A., Bethesda, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 6 1984 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Their please remove carbon copies. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

34073
REG. NO.

| | | | | | |
|---|---|--|---|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | 2b. HOUR MIN. | |
| CLAYTON WALLACE MACKINTOSH | | December 23 1984 | | 4 20 P | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YEAR | |
| MALE | WHITE | MONTH DAY YEAR | 74 | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| WASHINGTON DC | UNITED STATES | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| TAKOMA PARK | WASHINGTON ADVENTIST HOSPITAL | RETIRED | U.S. COV.T. | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
| MD | P.C. | Adelphi | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 9250 Edwards way #304 20783 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | |
| WILLIAM E. MACKINTOSH | | NELLIE WARNER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| No | | 598-03-7242 | Stuart mackintosh - 9250 EDWARDS WAY 20783 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Cerebral INFARCTION | | | | | 12/20/84 |
| DUE TO, OR AS A CONSEQUENCE OF (b) High blood pressure | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) PNEUMONIA | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | |
| WHITE <input type="checkbox"/> NEG. WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (the hospital) attended the deceased from 12-20, 1984, to 12/23/84, 1984, that (1) (we) lost saw the deceased alive on 12/22/84, 1984, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| Robert Gerwin MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 12/23/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| Robert Gerwin MD | | 7500 HANOVER PKWY GREENBELT MD 20770 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION | | |
| Burial | 12/27/84 | Gate of Heaven | CITY OR TOWN COUNTY STATE | | |
| | | | Silver Spring, Md. | | |
| 24. FUNERAL DIRECTOR | | | 25a. DATE RECEIVED BY REGISTRAR | | |
| Mitchell-Wiedefeld Home-6500 York Rd. Balto. | | | 25b. REGISTRAR'S SIGNATURE | | |
| | | | 21212 EC27 1984 | | |

BP _____

DEC 27 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 4 0 7 4
REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Adelina D. Madero | | | 2a. DATE OF DEATH MONTH DAY YEAR
Dec. 26, 1984 | | | 2b. HOUR
1:45 P.M. | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
January 21, 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE
(COUNTRY)
Italy | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Wheaton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Univ. Convalesc. & Nurs. Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY
Crown Cork & Seal Factory | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE
1635 Belvedere Boulevard 20902 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Domenic Madero Rosina Donato | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rosina Donato | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO.
220-10-7689 | | 17. INFORMANT
Samuel Madero Brother Same as 13 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiac arrest | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
im-med | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) atherosclerotic cardiovascular | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) cancer of colon disease | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: no | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
11/19 8:45 P.M. 1984 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
2309 Shorefield Rd Wheaton Md. | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/19 8:45 19 84 to 12/26 84 19 84 , that (I) (we) lost saw the deceased alive on above, (I) (we) did not view the body after death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | | | | | |
| 22b. SIGNATURE
Walter E. Goetz | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
12/26/84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
WALTER E. GOETZ MD | | | 22e. ADDRESS
2309 SHOREFIELD RD WHEATON MD | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
Dec. 29, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring Mont. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Francis J. Collins | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 31 1984 | | | | | | |
| 500 University Blvd., W. Silver Spring, Md. | | | | | 25b. REGISTRAR'S SIGNATURE
Gina Davidson-Randall | | | | | | |

BP.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

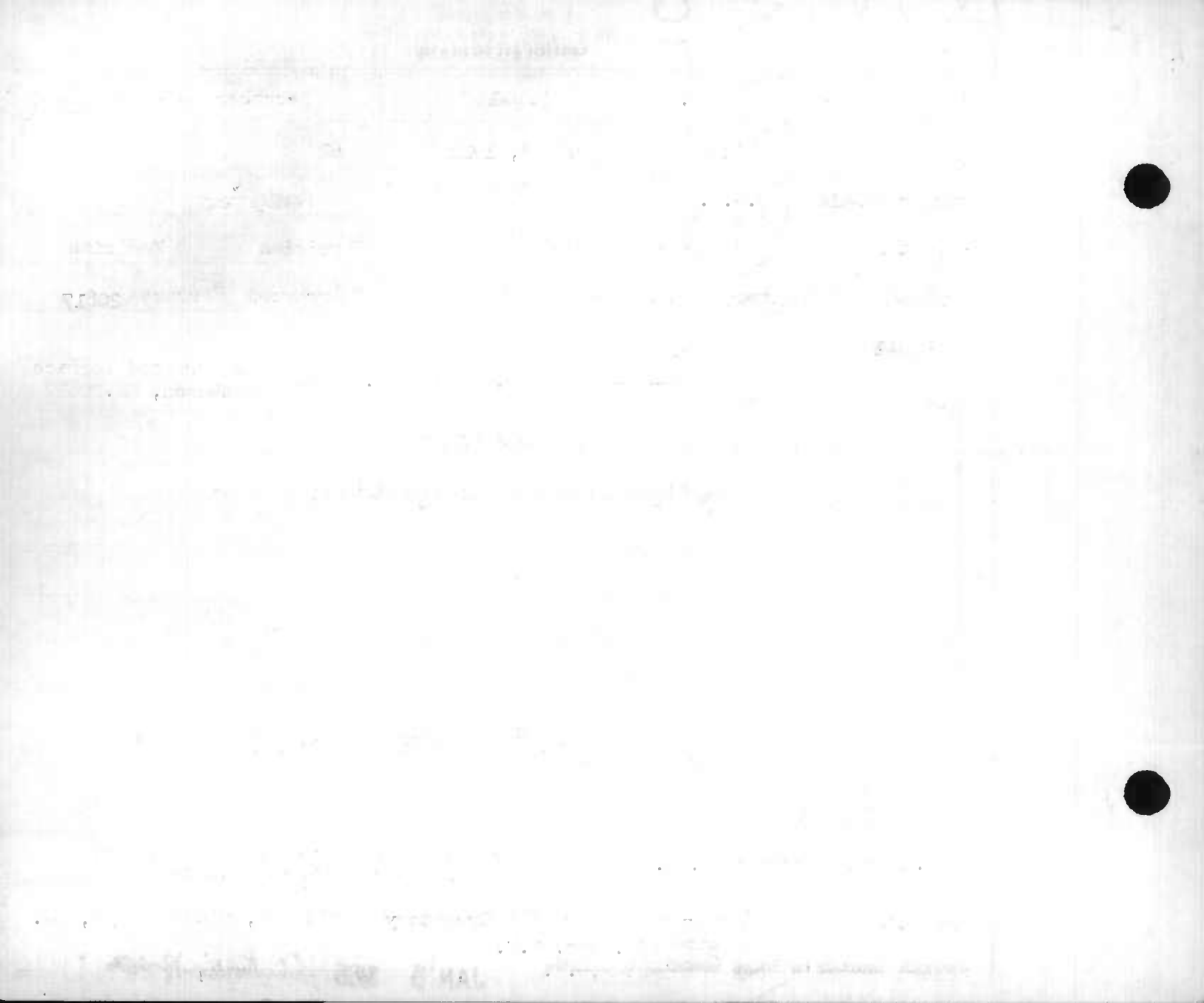
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "yes", the medical examiner must be notified by phone.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 3 4 0 7 5 | | REG. NO. | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
Ivan V. Magal | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 28 1984 | | 2b. HOUR
5:52P M | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 3, 1922 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS. | | 7. UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Czechoslovakia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Physician | | 12b. KIND OF BUSINESS OR INDUSTRY
Medicine | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2 Arrowood Terrace 20817 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Vasil Magal | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
224-46-1911 | | 17. INFORMANT
Dr. Charles P. Magal
ADDRESS 2 Arrowood Terrace
Bethesda, Md. 20817 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Myocardial Infarction</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec. 5</u> , 19 <u>84</u> , to <u>Dec. 28</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>Dec. 28</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Magal</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12/30/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
P. Jacob Varghese M. D. | | | | 22e. ADDRESS
George Washington Uni. Hospital
Washington D.C. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
12-30-84 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland, Prince Georges, Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Joseph Gawler's Sons | | | | ADDRESS
5130 Wis. Ave. N.W.
Washington, D.C. | | 25a. DATE REC'D. BY REGISTRAR
JAN 3 1985 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Swinton-Rosen</u> | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

34076
REG. NO.

| | | | | | | | | | |
|--|--|--|---|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
STEPHEN V MALENAS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 8 84 | | | 2b. HOUR
5:25 AM | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
June 30, 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Lithuania | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SUBURBAN HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY
Pulp & Paper | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
19439 Brassie Place #203 20879 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Jonas Malinauskas | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Natalie Saulynas | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
059-26-3643 | | 17. INFORMANT
ADDRESS
Stase Malenas, same as #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiovascular Collapse
DUE TO, OR AS A CONSEQUENCE OF (b) possible pulmonary embolus
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 minutes | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0 | | | | | | | | | |
| 19a. DATE OF OPERATION
12/6/84 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Right renal calculus | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/3/84 to 12/8/84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not (odd) (checked) how the body after death) | | | | | | | | | |
| 22b. SIGNATURE
Mark H. Hines MD | | 22c. ADDRESS
10401 Old Georgetown Rd | | 22d. DATE SIGNED
12/8/84 | | | | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
EMERGENCY | | 22f. ADDRESS
10401 Old Georgetown Rd | | 22g. DATE SIGNED
12/8/84 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
December 12, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Casimir Cemetery, Chicago, Illinois | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Chicago IL 60614 | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland 20814 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 13 1984 | | | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | | |

3

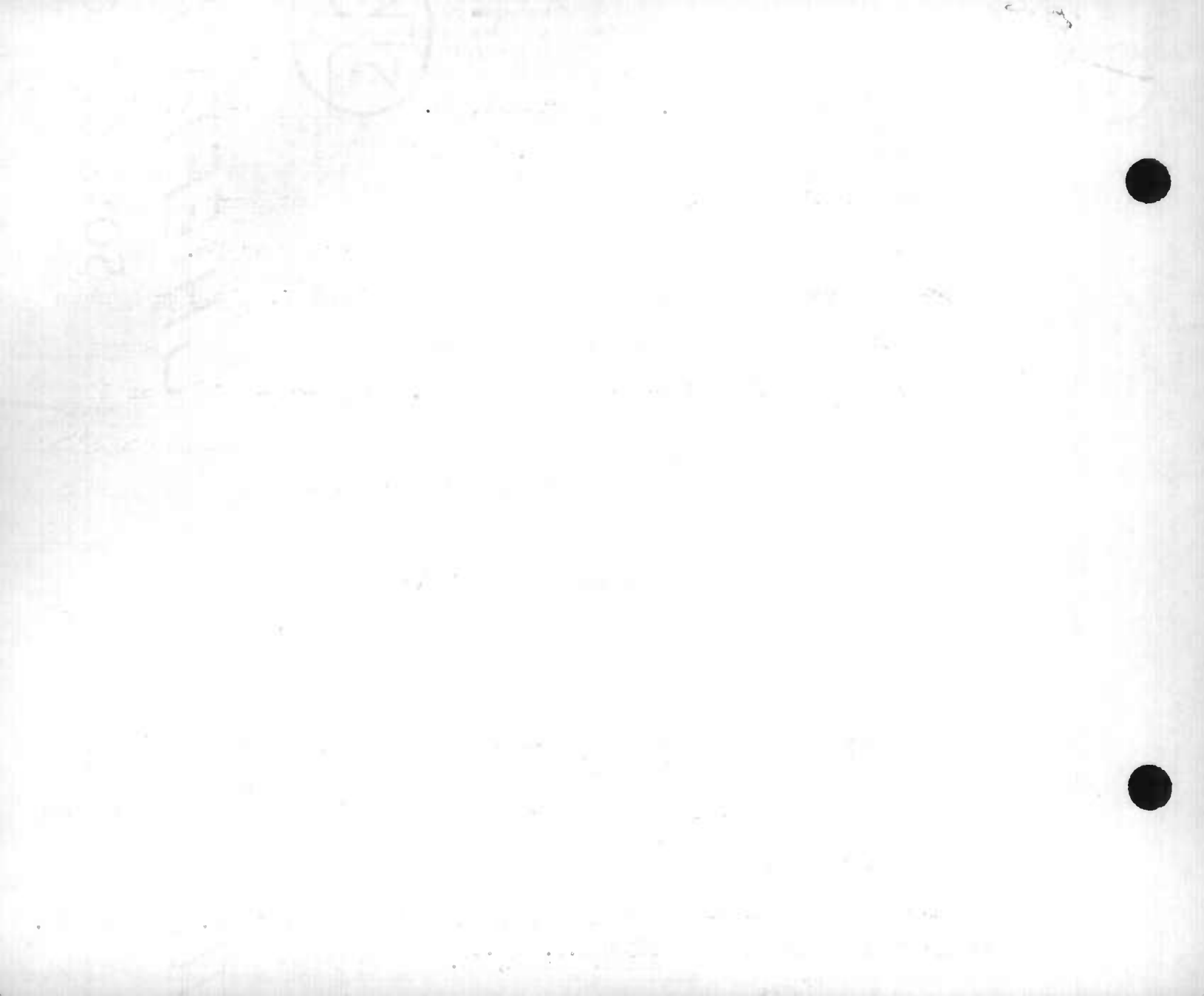


STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

34077

REG. NO.

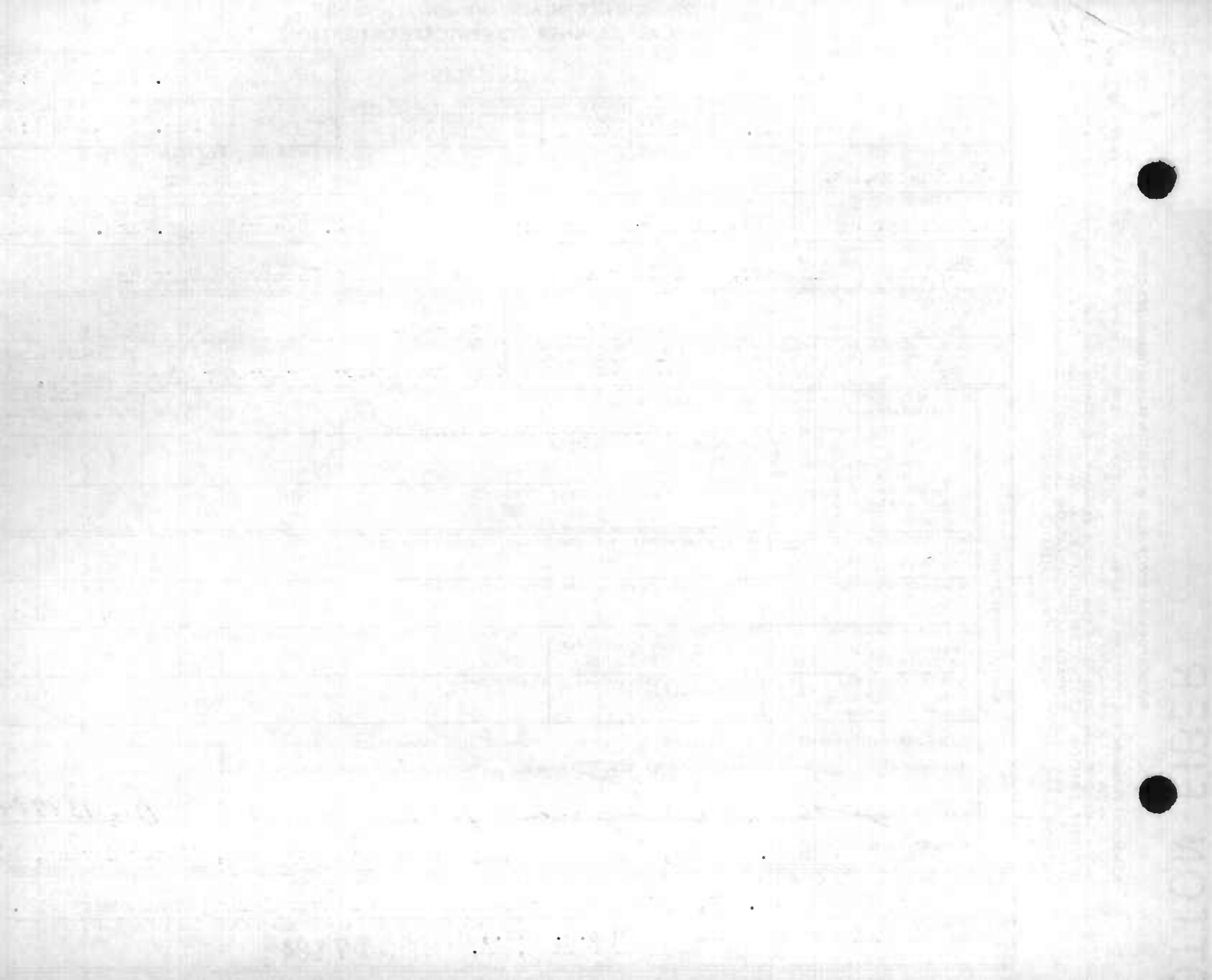
| | | | | | | | |
|--|--|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
JOHN F. MALONEY, SR. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 15 84 | | | 2b. HOUR
P M
6:30 P | |
| 3. SEX
Male | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb. 20 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, DC | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Highland | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
6715 Montell Drive | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Tavern Owner Ret. | | 12b. KIND OF BUSINESS OR INDUSTRY
Self Employed | |
| 13a. STATE
Florida | | 13b. COUNTY
Brevard | | 13c. CITY OR TOWN
Cocoa Beach | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
1305 S. Atlantic Avenue | | 14. FATHER'S NAME
FIRST MIDDLE LAST
Thomas | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Delia Conway | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
N/A | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | | 17. INFORMANT
Eleanor D. Maloney-wife | | ADDRESS
Same as 13E | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>gangrene. foot</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>peripheral vascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 month. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<u>metastatic carcinoma prostate</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) this hospital attended the deceased from <u>Nov 25</u> , 19 <u>84</u> to <u>Dec 15</u> , 19 <u>84</u> . that (2) (we) last saw the deceased alive on <u>Nov 25</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (and) not view the body after death. | | | | | | | |
| 22b. SIGNATURE
Edward P. Taubman | | | | DEGREE
MD. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/16/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Edward P. Taubman | | | | 22e. ADDRESS
1811 Prince Philip Dr., omey Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12-19-84 | | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood Pr. Georges Md. | |
| 24. FUNERAL DIRECTOR
Hines/Rinaldi Funeral Home | | | | 1800 N.H. Ave.
Silver Spring, Md. | | 25a. DATE REC'D. BY REGISTRAR
DEC 17 1984 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR
STATE
REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 3 4 0 7 8
REG. NO. | |
|--|--|----------------------------------|--|--|--|--|--|---|--|---|--|--|--|---|--|------------------|--|--|--|-----------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) JOEL MARGOLIS | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR Dec. 13 1984 | | | | | | | | | | 2b. HOUR 1:40 | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH
MONTH DAY YEAR Mar. 3 1915 | | 6. AGE (IN YEARS)
LAST BIRTHDAY YRS. 69 | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR Dec. 13 1984 | | 7d. HOUR 1:40 | | 7e. MIN A | | 7f. SEC M | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, DC | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
106 Fleetwood Terrace | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Asst. General Mngr. Wash. Redskin | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
106 Fleetwood Terrace 20902 | | | | | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Lewis Margolis | | | | | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bessie Cohen | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) N/A | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) N/A | | 17. INFORMANT
ADDRESS 1828 Billman Lane
Day Kreuzburg-son-in-law-Silver Spring, Md | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | | | APPROXIMATE TIME BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
None | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
none | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | | | | | | | TITLE (SPECIFY)
MEDICAL EXAMINER | | | | DATE SIGNED Dec 13 1984 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, DME | | | | | | | | | | ADDRESS 1919 Seminary Road, Silver Spring, Md | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
Dec. 17, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring Montgomery Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Hines/Rinaldi Funeral Home 11800 N.H. Ave. silver Spring, Md. | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 17 1984 | | | | 25b. REGISTRAR'S SIGNATURE
 | | | | | | | |

BP

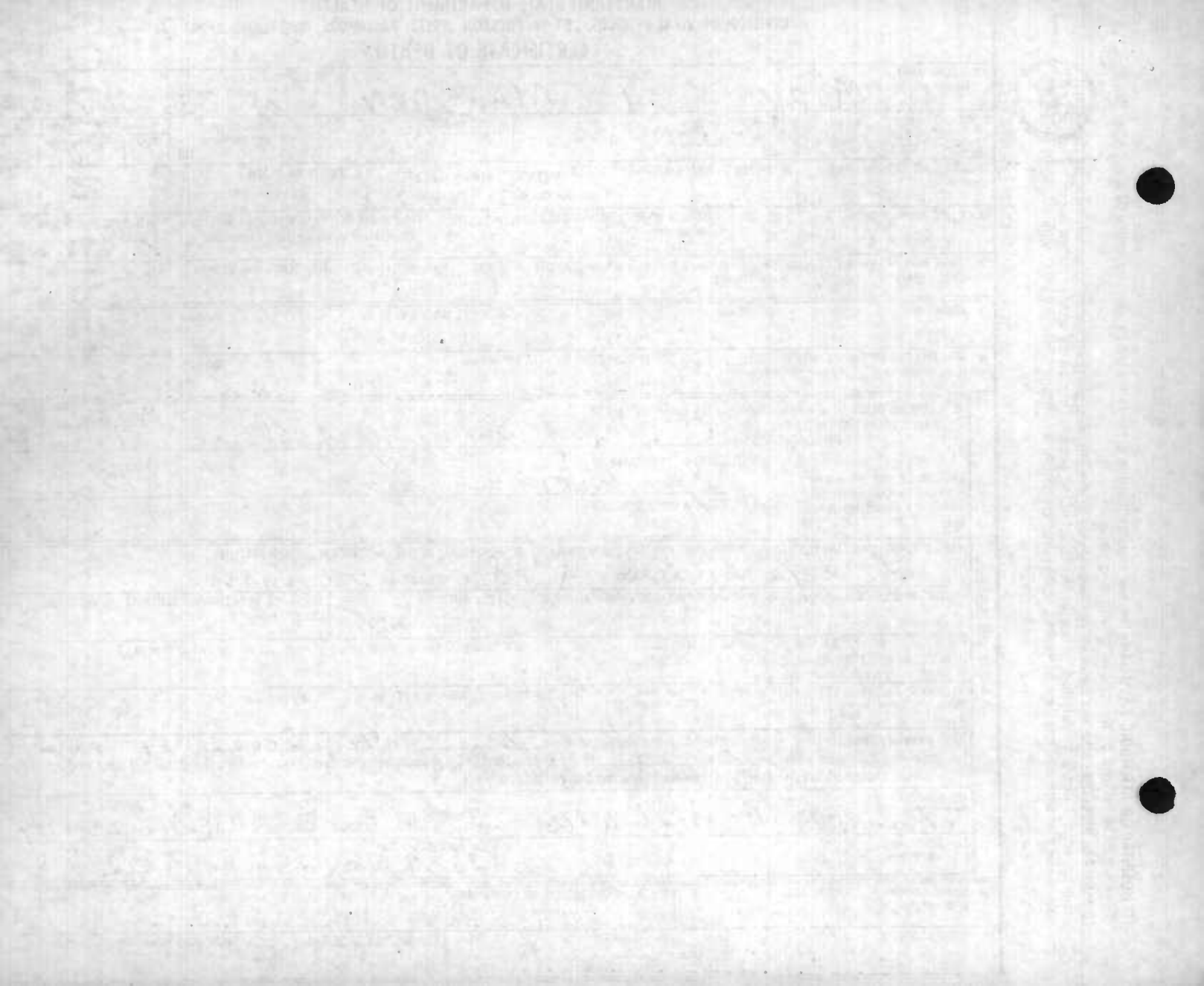


CERTIFICATE OF DEATH

| | | | | | | | | | |
|--|--|--|--------|--|-------------------|--|------|--|--|
| 1. DECEASED NAME
(Type or print) | | First | Middle | Last | 20. DATE OF DEATH | | | 2b. HOUR | |
| MARY | | | M | MARSDEN | Month | Day | Year | 10 P.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | |
| FEMALE | | CAUCASIAN | | SEPT 15, 1884 | | 100 YRS. | | MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | |
| WASHINGTON, D.C. | | U.S.A. | | | | MONTGOMERY | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| BETHESDA | | 8611 RAYBURN ROAD | | TEACHER | | D.C. PUBLIC SCHOOLS | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| MARYLAND | | MONTGOMERY | | BETHESDA | | | | 8611 RAYBURN ROAD 20817 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| FRANCIS | | LUCIAN | | MARY | | E. | | CARRAHER | |
| NO | | 579-60-8222 | | MARY E. JOSEPH | | SAME AS 13 | | NIECE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | Cardio-pulmonary failure | | | | 1-4 weeks | |
| | | | | Gen. arteriosclerosis | | | | 15 yrs | |
| | | | | (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| Leye enucleated. | | Sternal tumor | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Mar., 1974, to Dec 22, 1984, that (I) (we) saw the deceased alive on Dec 22, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | |
| Thomas F. McMahon MD | | Dec 23-1984 | | THOMAS F. McMAHON | | 2737 Devonshire Pl N.W. D.C. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| BURIAL | | 12/27/84 | | MT. OLIVET CEMETERY | | WASHINGTON, D. C. | | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| FRANCIS J. COLLINS | | DEC 31 1984 | | John Barbaresi | | | | | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | DATE | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 34080 | | | |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 1. DECEASED NAME (TYPE OR PRINT) | | | |
| FIRST MIDDLE LAST
William V. Marsden | | | | 2a. DATE OF DEATH MONTH DAY YEAR
Dec. 6, 1984 | | | |
| 2b. HOUR
5:08 AM | | | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
Nov. 14, 1906 | | 6. AGE IN YEARS (LAST BIRTHDAY)
78 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Arkansas | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Mechanic | | 12b. KIND OF BUSINESS OR INDUSTRY
PEPCO | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
15101 Interlachen Drive | | 14. FATHER'S NAME FIRST MIDDLE LAST
Thomas J. Marsden | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary Elizabeth Hughes | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
578-01-5159 | | 17. INFORMANT
Almeda Grace Marsden | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE THROMBOSIS</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>CANCER OF COLON</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>SEPTEMBER</u> 19 <u>82</u> to <u>DECEMBER</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>NOVEMBER</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | 22b. SIGNATURE
<u>Edward T. Cullen MD</u> | | 22c. DATE SIGNED
12/7/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Edward T. Cullen MD | | | | 22e. ADDRESS
5454 Wisconsin Ave #1135 Chevy Chase Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
10Dec84 | | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood PG Md | |
| 24. FUNERAL DIRECTOR NAME
Robert E. Wilhelm Funeral Home | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 12 1984 | | 25b. REGISTRAR'S SIGNATURE
<u>John Davidson Roberts</u> | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

34081

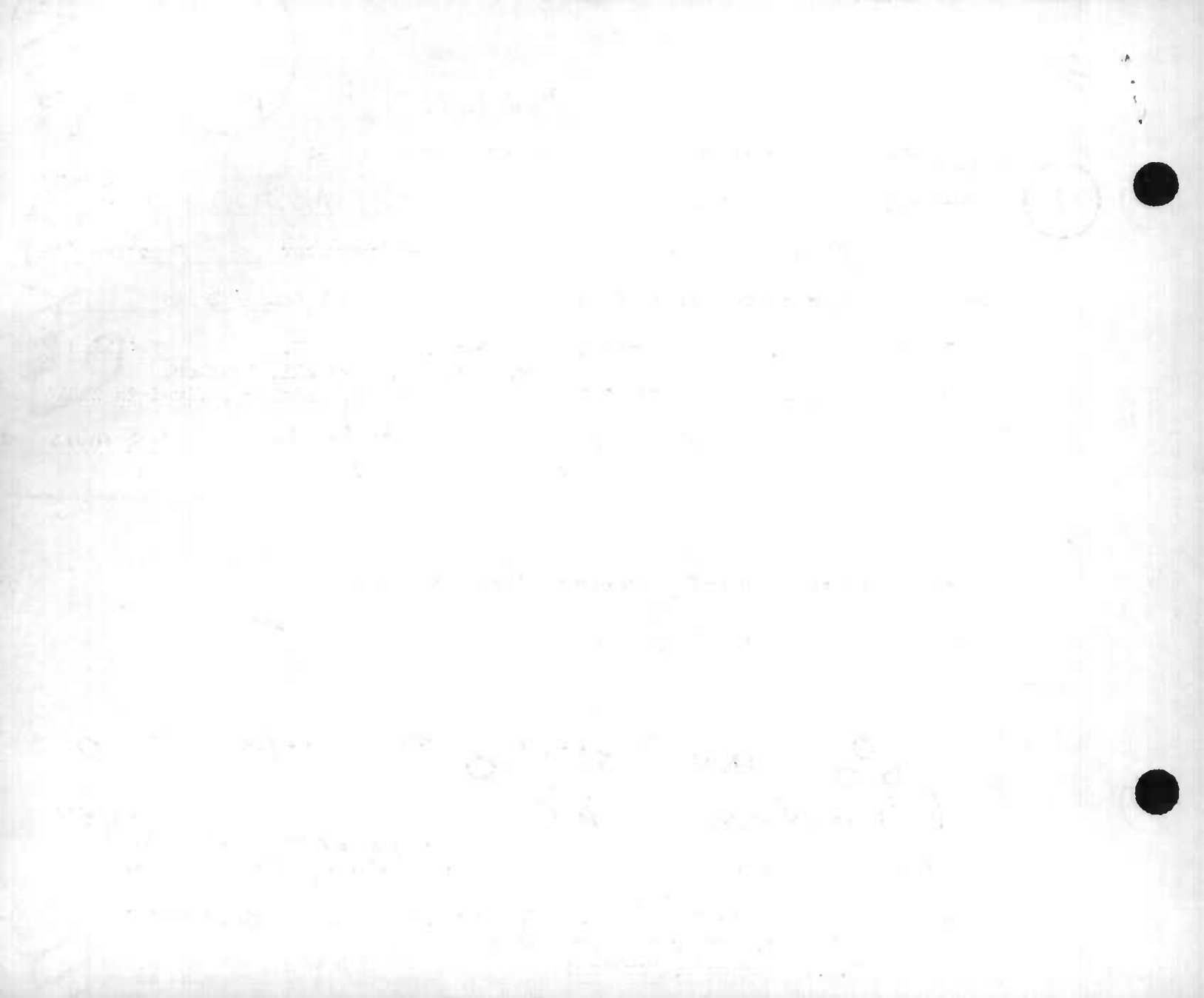
REG. NO.

| | | | | | |
|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | HOUR MIN. | |
| FIRST MIDDLE LAST | | 12-13-84 | | 6:40 P.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | |
| Male | | Caucasian | | MONTH DAY YEAR | |
| | | | | November 18, 1930 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Maryland | | United States | | 54 YRS. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Bethesda | | Suburban Hospital | | County Montgomery MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Excavator | | Construction | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| Maryland | | Montgomery | | Cabin John | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | |
| Isaac P. Marshall | | Martha I. Phillips | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | 218-24-3726 | | Mr. Harold V. Marshall, Brother, Route 3, Box 447, Edinburg, Virginia 22824 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| Acute Myocardial Infarction | | | | | 48 hours |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 110 | | | | | |
| POSTCAVAL SHUNT; CHRONIC LUNG DISEASE | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | |
| | | HOUR A.M. MONTH DAY YEAR | | | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from 12/11, 1984, to 12/13, 1984, that (1) (we) lost saw the deceased alive on 12/13, 1984, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| Ralph Coan | | M.D. | | 12/17/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| RALPH COAN M.D. | | 4400 EAST WEST HWY, BETHESDA, Md. 20814 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Cremation | | December 15, 1984 | | Metropolitan Crematory | |
| | | | | CITY OR TOWN COUNTY STATE | |
| | | | | Alexandria, Virginia | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Robert A. Pumphrey Funeral Homes P.A., Bethesda, Maryland | | DEC 18 1984 | | P. Davidson Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and place them in the envelope provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



BH

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 4 0 8 2

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) DOROTHY VIRGINIA MARTIN | | | 2a. DATE OF DEATH MONTH DAY YEAR
DECEMBER 6, 1984 | | | 2b. HOUR P M
9:25 P M | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
APRIL 29, 1922 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
62 | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE CLINICAL CENTER | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Bookkeeper | | 12b. KIND OF BUSINESS OR INDUSTRY
Stark Office | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE MARYLAND 13b COUNTY | | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
505 SOUTH UMBRA ST 21224 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Lacey | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO.
220-01-1179 | | 17. INFORMANT (SON)
THOMAS L. MARTIN | | ADDRESS
1202 BROENING HWY
BALTIMORE, MD 21224 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive Upper Gastrointestinal Bleeding
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) }
DUE TO, OR AS A CONSEQUENCE OF (c) } | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a
Lymphoma | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JUNE 17 , 19 83 to DECEMBER 6 , 19 84 , that (we) last saw the deceased alive on DECEMBER 6 , 19 84 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (X) we (did) not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Matthew Brenner | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/7/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Matthew Brenner | | | 22e. ADDRESS
NATIONAL INSTITUTES OF HEALTH
CLINICAL CENTER, BETHESDA, MARYLAND 20205 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | | 23b. DATE
12-10-84 | | 23c. NAME OF CEMETERY OR CREMATORY
Westview Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Westview, Balto. Co., Md. | | |
| 24. FUNERAL DIRECTOR NAME
Charles S. Zeiler & Son Inc. | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 10 1984 | | 25b. REGISTRAR'S SIGNATURE
a Davidson-Randall | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

(10)

2000 1000 2000 2000

11-11

1-1

1-1 1-1 1-1 1-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

34083

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|--|---|--|--|-----------------------------------|------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Emily Matke | | | 2a. DATE OF DEATH
MONTH 12 DAY 4 YEAR 84 | | | 2b. HOUR
7:52 P.M. | | | |
| 3. SEX
Female | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH FEB DAY 5 YEAR 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD | | | |
| 10. CITY OR TOWN OF DEATH
TAKOMA PARK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
WASHINGTON ADVENTIST HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
MARYLAND | | 13b. CITY OR TOWN
ANNE ARUNDEL SEVERN | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS
1843 ROBIN COURT | | 21144 | |
| 14. FATHER'S NAME
FIRST GUS MIDDLE VINOSY LAST VINOSY | | | | 15. MOTHER'S MAIDEN NAME
FIRST PIROS MIDDLE DOROGY LAST DOROGY | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
273-09-4047 | | 17. INFORMANT
RANDALL MATKE | | ADDRESS
SAME AS 13 | | SON | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Respiratory Failure**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **Chronic Obstructive Pulmonary Disease**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Cigarette Smoking**

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

Atherosclerotic Heart Disease, Congestive Heart Failure

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 12/4 19 84 to 12/4 19 84 , that (I) (we) lost saw the deceased alive on 12/4 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | |

| | | | | | | | |
|--|--|---------------------|--|--|--|------------------------------------|--|
| 22b. SIGNATURE
Gaston Elson | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/5/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
NORTON ELSON | | | | 22e. ADDRESS
6525 Belcrest Rd Hyattsville MD | | | |

| | | | | | | | |
|---|--|-----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
12/8/84 | | 23c. NAME OF CEMETERY OR CREMATORY
OUR LADY OF MERCY | | 23d. LOCATION
CITY OR TOWN MIAMI COUNTY DADE STATE FLORIDA | |
| 24. FUNERAL DIRECTOR FRANCIS J. COLLINS
NAME 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 ADDRESS | | | | 25. DATE REC'D. BY REGISTRAR DEC 10 1984 REGISTRAR'S SIGNATURE J. A. Davidson | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 34084
REG. NO. | |
|---|--|------------------------------|--|---|--|---|--|----------------------------|--|--|-------|
| 1. FOR STATE REGISTRAR | | | 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| | | | Stephen - Matovich | | | December 22 '84 | | | M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Male | | White | | June 8 1923 | | 61 YRS. | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Indiana | | U.S.A. | | | | Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Darnestown | | | 15110 Springfield Road | | | Safety Director | | | Dept. of Energy | | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | |
| Md. | | | Montgomery | | Darnestown | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 15110 Springfield Rd. 20707 | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| Stephen - Matovich | | | | | Mary - Orf | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT (Son) | | ADDRESS | | |
| Yes WWII | | | | | 310-14-2850 | | Laine Matovich | | 6307 County Dr. Disputanta, Va. 23842 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>metastatic pancreatic</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| | | | HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | STREET | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 19 27 to 12 19 84, that (I) (we) lost saw the deceased alive on 12/13/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | |
| Ronald E. Greger, M.D. | | | | | | | | | 12/22/84 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | | | |
| | | | | | 20878 12105 Darnestown Rd., Gaithersburg, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | | |
| Cremation | | | 12/24/84 | | Lee's Crematory | | | Washington, D. C. | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Gartner Sandison F.H. 316 E. Diamond Ave., Gaithersburg, Md. 20877 | | | | | DEC 31 1984 | | | Julia Davidson-Randall | | | |



CHIEF



UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535
JAN 10 1964
MEMORANDUM FOR THE DIRECTOR
SUBJECT: [Illegible]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE. IF THE DEATH IS SUICIDE, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE. IF THE DEATH IS SUICIDE, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE. IF THE DEATH IS SUICIDE, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | | |
| 2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 1 84 205 P M | | | | | | | | | | | |
| 2b. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 1 84 205 P M | | | | | | | | | | | |
| 3. DECEASED NAME FIRST MIDDLE LAST Hilda Jones May | | | | | | | | | | | |
| 4. SEX Female | | | | | | | | | | | |
| 5. RACE Caucasian | | | | | | | | | | | |
| 6. DATE OF BIRTH MONTH DAY YEAR Feb. 7, 1898 86 YRS. | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts | | | | | | | | | | | |
| 7b. CITIZEN OF WHAT COUNTRY? United States | | | | | | | | | | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Chevy Chase | | | | | | | | | | | |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5526 Warwick Place | | | | | | | | | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Public Relations | | | | | | | | | | | |
| 12b. KIND OF BUSINESS OR INDUSTRY Red Cross | | | | | | | | | | | |
| 13a. STATE Maryland | | | | | | | | | | | |
| 13b. COUNTY Montgomery | | | | | | | | | | | |
| 13c. CITY OR TOWN Chevy Chase | | | | | | | | | | | |
| 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 13e. STREET ADDRESS 5526 Warwick Place 20815 | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Henry V. Jones | | | | | | | | | | | |
| 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Dewey | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | | | | | | | | |
| 16b. SOCIAL SECURITY NO. 110 16 5079 | | | | | | | | | | | |
| 17. INFORMANT Christopher May Son same as 13e | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest.
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Coronary arteriosclerosis.
(c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Parkinson's Disease. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | | | | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | | | | | | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | | | | | | |
| 21f. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE John Tauber TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER DATE SIGNED 12-1-84. | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) John Tauber ADDRESS 8218 Wisconsin Ave | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | | | | | | | | | |
| 23b. DATE Dec. 2, 1984 | | | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory | | | | | | | | | | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, ADDRESS P.A., Bethesda, Maryland 20814 | | | | | | | | | | | |
| 25a. DATE REC'D. BY REGISTRAR DEC 5 1984 | | | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE John Tauber | | | | | | | | | | | |

DAVID

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

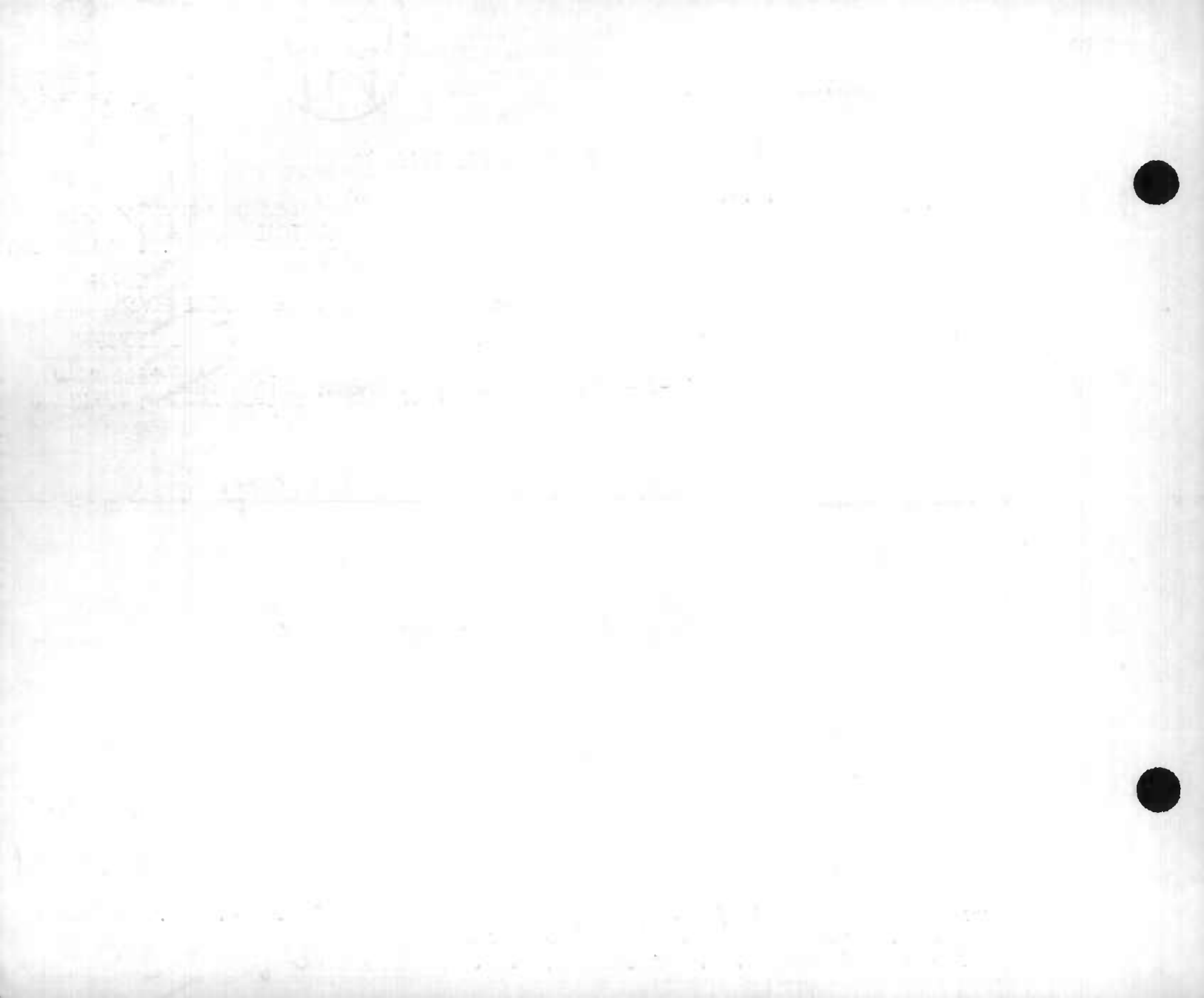
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 34080 | |
|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) DANIEL | | MIDDLE G. | LAST MAZUR | 2a. DATE OF DEATH MONTH December DAY 16 YEAR 1984 | |
| 3. SEX MALE | | 4. RACE WHITE | 5. DATE OF BIRTH MONTH FEBRUARY DAY 11 YEAR 1916 | | 2b. HOUR 2:40 P |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. AGE (IN YEARS LAST BIRTHDAY) 68 | | IF UNDER 1 YEAR MONTHS DAYS |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD. | | IF UNDER 24 HRS. HOURS MIN. |
| 13a. MARYLAND | | 13b. CITY OR TOWN SILVER SPRING | 13c. STREET ADDRESS / ZIP CODE 10606 MEADOWHILL ROAD 20901 | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. GOVERNMENT |
| 14. FATHER'S NAME FIRST SAMUEL MIDDLE LAST MAZUR | | 15. MOTHER'S MAIDEN NAME FIRST ESTHER MIDDLE LAST ERLICHMAN | | 12a. USUAL OCCUPATION (THE DECEASED'S USUAL WORKING LIFE) ENGINEER | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (S, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 033-07-6281 | | 17. INFORMANT ADDRESS ELEANOR A. MAZUR, 10606 MEADOWHILL ROAD SILVER SPRING, MARYLAND | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Aneurysm
DUE TO, OR AS A CONSEQUENCE OF (b) Sub Dural hemorrhage
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION 12-12-84 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Sub dural Hemorrhage | | 19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 1980 | | 21c. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-16-84 to 12-16 , 19 84 , that (I) (we) lost saw the deceased alive on 12-16-84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Robert Kramer DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/16/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT KRAMER | | 22e. ADDRESS 10313 Georgia Ave Sc/886 Rd | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 12/19/1984 | | 23c. NAME OF CEMETERY OR CREMATORY MOUNT LEBANON CEMETERY | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE ADDELPHI, PR. GEO., MARYLAND | | 23e. NAME OF FUNERAL HOME HEBREW MEMORIAL FUNERAL HOME | | 23f. ADDRESS 232 CARROLL STREET, N. W., WASHINGTON, D. C. | |
| 24. DATE REC'D. BY REGISTRAR DEC 24 1984 | | 25. REGISTRAR'S SIGNATURE Davidson-Rendell | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked as item 18, any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 34081
REG. NO. | |
|---|--|---|--|---|---|---|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Ethel E. McCaffrey | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 25 84 | | | 2b. HOUR
3:25 A.M. | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 12 94 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASH. D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF BUSINESS OR WORKING LIFE)
Retired | | | 12b. KIND OF BUSINESS OR INDUSTRY
Dept. Store | | |
| 13a. STATE
Maryland | | 13b. COUNTY
P.G. | | 13c. CITY OR TOWN
Hyattsville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
6003 36th Ave. 20782 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Welsh | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Liza Holson | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
577-10-0126A | | 17. INFORMANT
Doris M. Clancy | | | ADDRESS: 6003 36th Avenue Hyattsville, Md. 20782 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF
(b) arteriosclerotic heart disease
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 hrs
YRS. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Diabetes Mellitus | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NO: WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/12 19 84 , to 12/25 19 84 , that (I) (we) lost
saw the deceased alive on 12/24 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
R.T. Benack MD | | | | | | DEGREE
MD | | | 22c. DATE SIGNED
12/25/84 | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
R.T. Benack MD | | | | | | 22a. ADDRESS
4115 Colie DR. Wheaton, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
12/28/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Fort Myer Arlington Virginia | | | |
| 24. FUNERAL DIRECTOR
Francis Gasch's Sons Funeral Home, P.A. | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 27 1984 | | | 25b. REGISTRAR'S SIGNATURE
Sheila Davidson-Randall | | |

BP

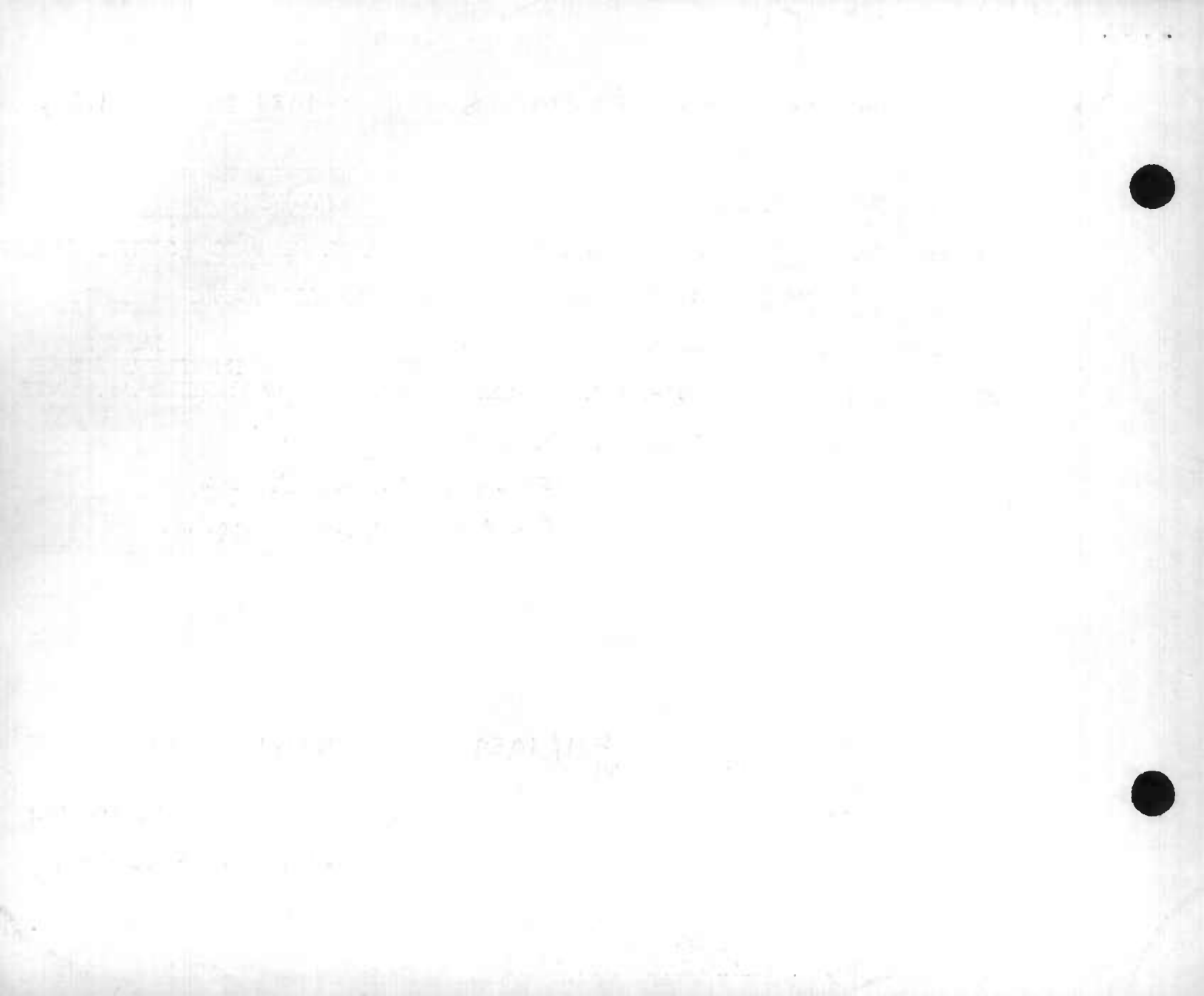


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 3 4 0 8 8 | | | |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) GEORGIE HALL McDONALD. | | | | 2a. DATE OF DEATH MONTH DAY YEAR 12/18/84 | | | |
| 3. SEX MALE | | | | 2b. HOUR 1.26 AM | | | |
| 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR JAN 8, 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH GAITHERSBURG | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WILSON HEALTH CARE CENTER | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ASST. MECHANIC | | 12b. KIND OF BUSINESS OR INDUSTRY CAPITAL TRANSIT | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN SILVER SPRING | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WALTER P. McDONALD | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALIZA JACKSON | | 13e. STREET ADDRESS / ZIP CODE 603 SLIGO AVENUE 20910 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 579-14-0167 | | 17. INFORMANT WIFE ADDRESS 277 RUSSELL AVENUE GAITHERSBURG, MD. 20877 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO Respiratory Arrest. | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) STROKE SYNDROME, Dementia. | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) and Arteriosclerotic Heart Disease | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/11/1959 , 19 to 12/18/84 , that (I) (we) lost saw the deceased alive on 12/11/84 , 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Hamid Montakhab MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 12/18/1984 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAMID MONTAKHAB, | | | | 22e. ADDRESS 611 EXECUTIVE BLVD, ROCKVILLE MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 12/21/84 | | 23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD PRI GEO MD. | |
| 24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | 25a. DATE REC'D. BY REGISTRAR DEC 24 1984 25b. REGISTRAR'S SIGNATURE [Signature] | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 3 4 0 8 9
REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
James Martin McDonald Sr. | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12/15/84 | | | | 2b. HOUR
3:47pm | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR
JAN 19, 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASHINGTON, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
CIVIL ENGINEER | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
DERWOOD | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
18712 ROCKYWAY 20855 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
MARTIN McDONALD | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
SARAH B. GALLAGHER | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
WW II | | 17. INFORMANT ADDRESS
MABEL LOUISE McDONALD - SAME AS 13 WIFE | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis generally
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6:30pm 19 62, to 15 Dec 19 84, that (I) (we) lost above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Thomas Fogherty | | | | 22c. DATE SIGNED
15 Dec 84 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
THOMAS FOGHERTY | | | | 22e. ADDRESS
SILVER SPRING MONT MARYLAND | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
12/19/84 | | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | | 23d. LOCATION CITY OR TOWN COUNTY STATE
SILVER SPRING MONT MD. | | | |
| 24. FUNERAL DIRECTOR NAME
FRANCIS J. COLLINS | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 19 1984 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | | | | |

WORTH,

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 34090 | |
|---|--|---|--|---|--|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Eunice Ruth McDowell | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12 / 15 / 84 | | | 2b. HOUR
11 ³⁰ PM | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
Oct. 29 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY)
89 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5802 Ryland Drive | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY
own home | | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
5802 Ryland Drive 20817 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Joshua Townsend | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Lucy Emmaline Armstrong | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
N/A | | | | 16b. SOCIAL SECURITY NO.
213 74 5285 | | 17. INFORMANT
Lucille H. Smith-daughter-(same as 13e) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Atherosclerotic Cardiovascular Disease</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 years | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 19 82, to 12/18 84, that (I) (we) last saw the deceased alive on 12/15 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Michael Emmer | | | | DEGREE
MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/15/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Michael Emmer, MD | | | | 22e. ADDRESS
6316 Democracy Blvd., Bethesda, Md. 20817 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
12-18-1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Brentwood Pr. Georges Md. | | | |
| 24. FUNERAL DIRECTOR
Hines/Rinaldi Funeral Home | | | | | | 11800 N.H. Ave.,
S.S. Md. 20904 | | 25a. DATE REC'D. BY REGISTRAR
DEC 17 1984 | | 25b. REGISTRAR'S SIGNATURE
Julia Swisher | |

BP

64 EMERALD MAR 1977

10100 1000

HAL

10100 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|---|--|
| 1- FOR STATE REGISTRAR | | 8 4 3 4 0 9 1 | | | | REG. NO. | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
Paul J. McGrath | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 9, 1984 | | 2b. HOUR
8:50 PM | |
| 3 SEX
MALE | | 4 RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
SEPT 1, 1953 | | 6 AGE (IN YEARS LAST BIRTHDAY)
31 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASHINGTON, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | | |
| 10 CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
ACCOUNTANT | | 12b. KIND OF BUSINESS OR INDUSTRY
DEPT OF COMMERCE | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
WHEATON | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
11749 VIERS MILL ROAD 20902 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
FRANCIS MCGRATH | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
FLORENCE DEMPSEY | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
220-60-2343 | | 17 INFORMANT
ANITA L. MCGRATH | | ADDRESS
SAME AS 13 | | WIFE | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>anoxic encephalopathy</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>cardiac arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>pneumonia peritonitis</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 days
10 days
14 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
<u>diabetes mellitus chronic renal failure</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 21</u> , 19 <u>84</u> , to <u>Dec 9</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>Dec 9</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Mark S Rosen MD</u> | | | | DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/10/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Mark S Rosen MD | | | | 22e. ADDRESS
Silver Spring, MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
12/13/84 | | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
SILVER SPRING MONT MD. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 13 1984 | | | | | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | 25b. REGISTRAR'S SIGNATURE
<u>John Davidson-Randall</u> | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC. NO. 34092

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|---------|-------------------|---|--|--------------------------|--|--|--------------------------|------------------|--|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH | | | ESTIMATED MONTH DAY YEAR | | | 2b. HOUR | | | | | | | | | | | |
| GREGORY Anthony | | | MC KENZIE | | | 12 15 1984 | | | | | | | | | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | 2d. HOUR | | | | | | | | | |
| Male | | Black | | 10 5 63 | | 21 YRS. | | MONTHS DAYS HOURS MIN | | | | 12 15 1984 | | 12:58 PM | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| Jamaica, W.I. | | | | U.S.A. | | | | | | | | Montgomery County MD | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Takoma Park | | | | Washington Adventist Hosp. | | | | None | | | | None | | | | | | | | | | | |
| 13a. STATE | | | | | | | | | | | | 13b. COUNTY | | | | | | | | | | | |
| MD | | | | | | | | | | | | Prince Georges Hyattsville | | | | | | | | | | | |
| 13c. CITY OR TOWN | | | | | | | | | | | | 13d. INSIDE CITY LIMITS? | | | | | | | | | | | |
| | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 13e. STREET ADDRESS | | | | | | | | | | | | 13f. STREET ADDRESS | | | | | | | | | | | |
| | | | | | | | | | | | | 1702 Norton Road 20783 | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | 16. SOCIAL SECURITY NO. | | | | | | | | | | | |
| FIRST MIDDLE LAST | | | | | | FIRST MIDDLE LAST | | | | | | 17. INFORMANT ADDRESS | | | | | | | | | | | |
| Rupert McKenzie | | | | | | Norma Forbes | | | | | | 1702 Norton Road Hyattsville, MD 20783 | | | | | | | | | | | |
| 14a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | | | 14b. SOCIAL SECURITY NO. | | | | | | 17. INFORMANT ADDRESS | | | | | | | | | | | |
| No | | | | | | 579-86-7798 | | | | | | Norma McKenzie 1702 Norton Road Hyattsville, MD 20783 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Gunshot wound of chest (unspecified weapon) | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: | | | | | | | | | | | | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | |
| (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | | | | | | | | | |
| | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | 11:55xx 12-15-19 84 Subject shot. | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | | | | | | | | | | | | |
| | | | | street | | | | 14th & Kanawha Sts., Langley Pk., Prince George's Md. | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | | | | | | | | | | | |
| Ann M. Dixon, M.D. | | | | Assistant | | | | 12-16-84 | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | | | | | | | | | |
| Ann M. Dixon, M.D. | | | | 111 Penn St., Balto., Md. 21201 | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | | | | | | | | | |
| Burial | | | | 12/22/84 | | | | Harmony Memorial Park | | | | Landover Prince George's Md | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | | | | | | | | | | | | | | | | | | |
| ROLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, N.E. WASHINGTON, D.C. 20012 | | | | | | | | | | | | | | | | | | | | | | | |
| 25a. DATE REC'D BY REGISTRAR | | | | | | | | | | | | | | | | | | | | | | | |
| DEC 24 1984 | | | | | | | | | | | | | | | | | | | | | | | |

WASHINGTON, D.C. 20012
 4339 HUNT PLACE, N.E.
 ROLLINS FUNERAL HOME, INC.

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Landover Prince Georges Co

Anthony

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Jamaica, N.Y.

Prince Georges Hyattsville

1702 Norton Road

20753

Robert

McKenzie

Norma

Robert

574-80-775

Norma McKenzie

1702 Norton Road
 Hyattsville, MD 20753



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 34093
REG. NO. | |
|---|--|--|--|---|--|--|--|--|----------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Eleanor T. McKenna | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
December 3, 1984 | | | 2b. HOUR
6:00p M | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
May 14 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County Maryland MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
13300 Midway Avenue | | | | 12a. USUAL OCCUPATION
Licensed Practical Nurse | | 12b. KIND OF BUSINESS OR INDUSTRY
Hospital | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
13300 Midway Avenue Rockville, Md. 20851 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
William Ira Arnsperger | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Ann Patterson | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
129-14-8701 | | 17. INFORMANT ADDRESS
Patricia Ann McKenna (Daughter)
13300 Midway Avenue Rockville, Md. 20851 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
minutes | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease | | | | | | | | | | yrs. | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:
Diabetes Mellitus, Peripheral Vasc. Disease | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 1968 to 12/3 19 84 , that (I) (we) last saw the deceased alive on 12/3 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Raymond T. Benack M.D.
OF PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
December 4 1984 | |
| 22e. ADDRESS
4115 Colie Drive Wheaton, Maryland 20906 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
December 7, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Immaculate Conception Cemetery, Clinton, New Jersey | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR
NAME Robert A. Pumphrey ADDRESS Funeral Homes PA. 300 West Montgomery Avenue Rockville, Md. 20850 | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 7 1984 | | 25b. REGISTRAR'S SIGNATURE
Juha Davidson-Kendall | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

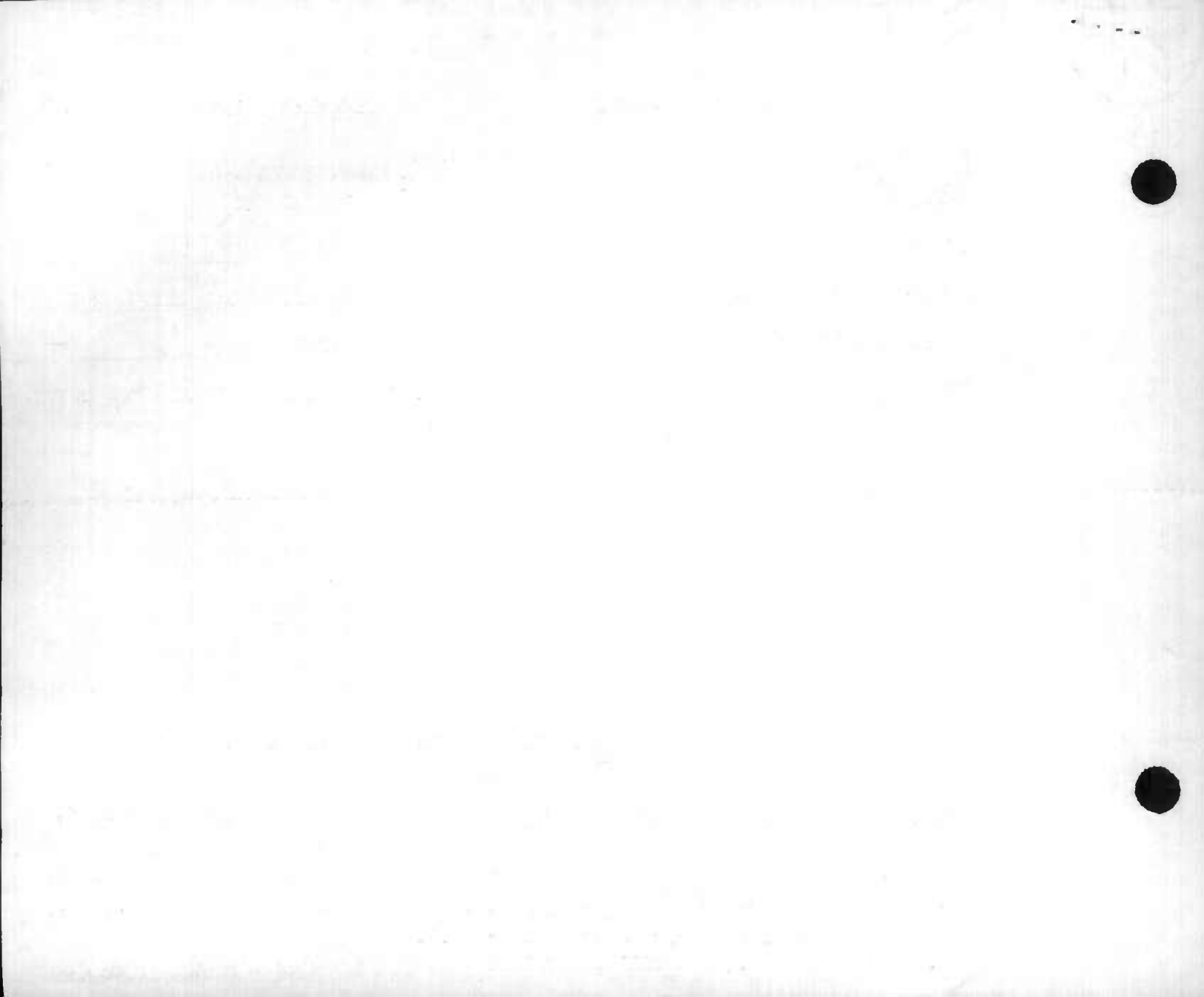
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified for ante.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

34094
REG. NO.

| | | | | | |
|---|--|---|---|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| I. DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | a m | |
| FIRST MIDDLE LAST | | DECEMBER 6 1984 | | 8:30 | |
| LAURA DENISE MCMANAMAN | | | | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (IN YEARS LAST BIRTHDAY) | 7 UNDER 1 YEAR | 8 UNDER 24 HRS |
| FEMALE | CAUCASIAN | MONTH DAY YEAR | YRS. | MONTHS DAYS | HOURS MIN. |
| | | DECEMBER 6 1984 | | | 23 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH | | |
| MARYLAND | UNITED STATES | | MONTGOMERY MD. | | |
| 10 CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| BETHESDA | NAVAL HOSPITAL | | N/A | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | | |
| 13a. STATE | 13b. COUNTY | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 8416 BUCKHANNON DRIVE 20854 | | |
| MARYLAND | MONTGOMERY | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | |
| VINCENT LEO MCMANAMAN | | CHRISTINE KATHY KEYS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS | |
| NO | | N/A | | VINCENT L. MCMANAMAN, 8416 BUCKHANNON DRIVE, POTOMAC, MD 20854 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) ANENCEPHALY | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 6 1984 to DECEMBER 6 1984, that (I) (we) last saw the deceased alive on DECEMBER 6 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| SUSAN M. BOISVERT | | MD | | 10 Dec 84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| S. M. BOISVERT, LT. MC. USNR | | NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA MD 20814 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | December 11/1984 | | Arlington National | |
| | | | | CITY OR TOWN COUNTY STATE | |
| | | | | Arlington, Virginia | |
| 24. FUNERAL DIRECTOR | | 24b. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Robert A. Pumphrey Funeral Homes, P.A. | | DEC 17 1984 | | Julia Newton-Randall | |
| 300 W. Montgomery Ave., Rockville, Maryland | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 34095
REG. NO. | | | |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) E. Noah Meadows | | | | December 10 '84 | | | |
| 3. SEX Male | | | | 4. RACE White | | | |
| 5. DATE OF BIRTH MONTH DAY YEAR December 16 1892 | | | | 6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va. | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH Gaithersburg | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12 Maryland Avenue | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher? | | | | 12b. KIND OF BUSINESS OR INDUSTRY Clerk 2 Stores | | | |
| 13a. STATE Md. | | | | 13b. COUNTY Montgomery | | | |
| 13c. CITY OR TOWN Gaithersburg | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13e. STREET ADDRESS 12 Maryland Ave. (20877) | | | | 14. FATHER'S NAME FIRST MIDDLE LAST Perry - Meadows | | | |
| 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah - Meadows | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) WWI | | | |
| 16b. SOCIAL SECURITY NO. 212-24-4578 | | | | 17. INFORMANT (Son) ADDRESS E. Dale Meadows Gaithersburg, Md. 20877 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis - Genl. DUE TO, OR AS A CONSEQUENCE OF (c) H.C.V.D. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 minutes | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: H.C.V.D. | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-10-84 to 12-10-84 , that (I) was last saw the deceased alive on 11-10-84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) was did not view the body after death. | | | | | | | |
| 22b. SIGNATURE Jack Schumacher M.D. DEGREE M.D. | | | | 22c. DATE SIGNED 12/10/84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jack Schumacher, M.D. | | | | 22e. ADDRESS 105 Russell Ave., Gaithersburg, Md. 20877 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 12/12/14 | | | |
| 23c. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Gaithersburg Montg. Md. | | | |
| 24. FUNERAL DIRECTOR Gartner Sandison F.H. | | | | 25a. DATE REC'D. BY REGISTRAR DEC 13 1984 | | | |
| 25b. REGISTRAR'S SIGNATURE Gartner Sandison F.H. | | | | 25c. ADDRESS 316 E. Diamond Ave., Gaithersburg, Md. 20877 | | | |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
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(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 4 0 9 7
REG. NO.1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | |
|--|--|------------------|-----------------|---|--|--|---|---|----------------|--|--|---|--|---|-------------------------|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST
NATHAN | | | MIDDLE
TYRONE | | | LAST
MELVIN | | | 2a. DATE KNOWN
OF DEATH
ESTIMATED
12-4-84 19 | | | 2b. HOUR
am
12:03 | | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept 9, 1951 | | | 6. AGE (IN YEARS)
LAST BIRTHDAY
33 YRS. | | | 7. IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN. | | 2c. DATE
PRONOUNCED
DEAD
12-4-84 19 | | | 2d. HOUR
am
12:03 | | | | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)
Wash., D. C. | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Takoma | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN HUGH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)
Clerk-Mgr. | | | | 12b. KIND OF BUSINESS
OR INDUSTRY
Unknown | | | | | |
| 13a. STATE
D. C. | | | | | | | | | | 13b. COUNTY
Washington | | 13c. CITY OR TOWN
Washington | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
302 T Street, N.E. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Augustus Melvin | | | | | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ruth Ford King | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
579-70-4365 | | | | 17. INFORMANT
ADDRESS
Ms. Shirley Melvin/sister/same as 9d | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I
<u>obesity</u> | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
(PARTIAL)
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above (PARTIAL) Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
<u>Margarita A. Korell</u> | | | | TITLE (SPECIFY)
M.D. Assistant | | | | MEDICAL EXAMINER | | | | DATE SIGNED 12-4-84 | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Margarita A. Korell, M.D. | | | | ADDRESS
111 Penn Street | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
2-11-84 | | 23c. NAME OF CEMETERY OR CREMATORY
Lincoln Memorial | | | | 23d. LOCATION
CITY OR TOWN
Suitland, Md. | | | | COUNTY STATE | | | | | |
| 24. FUNERAL DIRECTOR
NAME
John T. Rhines Co., 3015 12th St. N.E., D.C. | | | | | | | | | | 25a. DATE REC'D BY REGISTRAR
DEC 10 1984 | | | | | | 25b. REGISTRATION NUMBER | | | |

1

2

20% COTTON FIBER

CHINA WASH DOWD

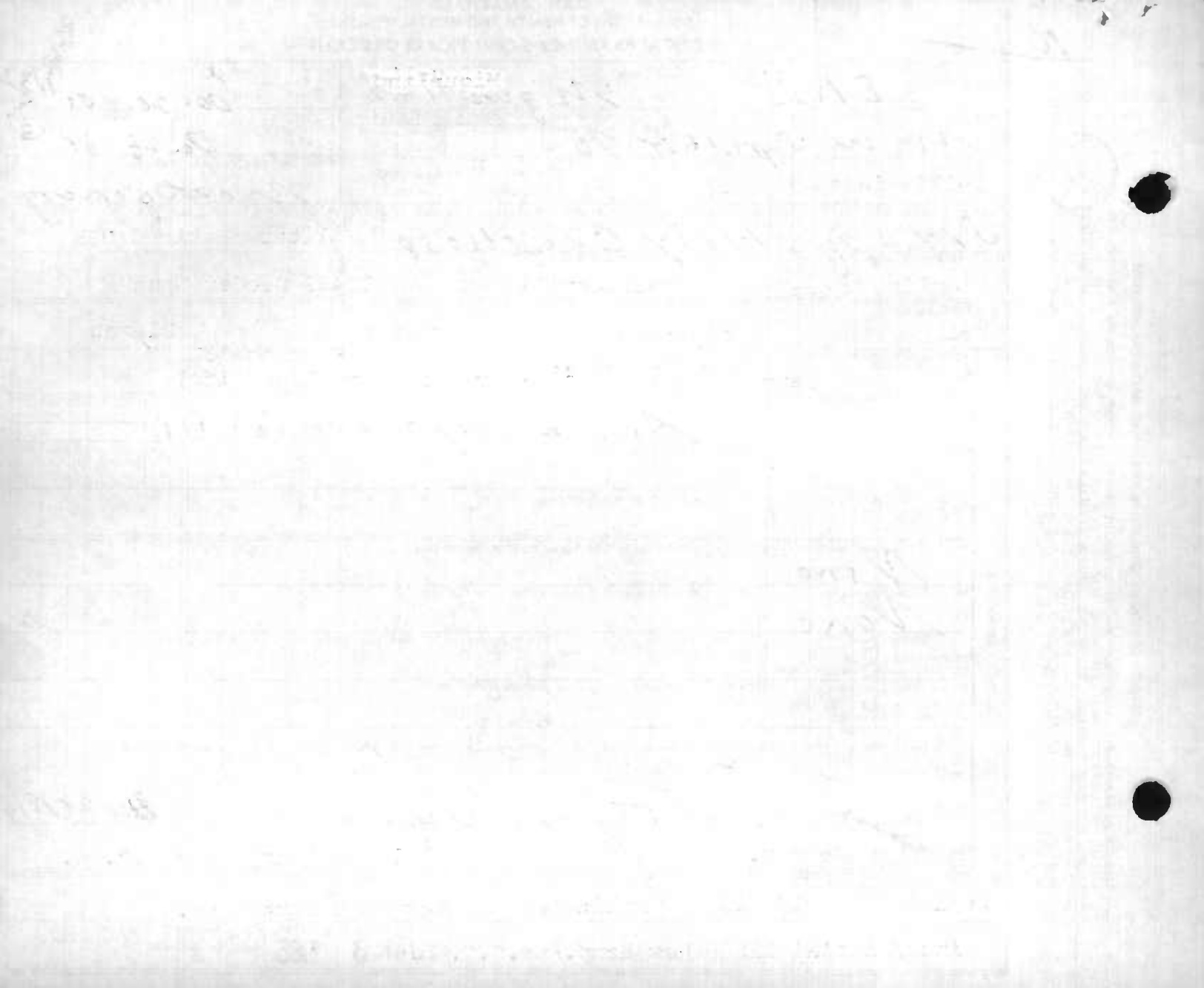
Wash DOWD

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 34098

| | | | | |
|---|--|---|---|---|
| 1. DECEASED NAME
(TYPE OF PRINT) Elias A. Miguelino | | 2a. DATE KNOWN OF DEATH
MONTH 11 DAY 28 YEAR 1984 | | 2b. HOUR OF DEATH
11:30 AM |
| 3. SEX
M | 4. RACE
W | 5. DATE OF BIRTH
MONTH 5 DAY 16 YEAR 1970 | 6. AGE (IN YEARS)
LAST BIRTHDAY 14 YRS. | 6. UNDER 1 YR. IF UNDER 24 HRS.
MONTHS 0 DAYS 12 HOURS 0 MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Philippines | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
S. J. Spgs | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hosp | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Military Retired USN | | |
| 13a. STATE
Florida | | 13b. COUNTY
Duval | 13c. CITY OR TOWN
Jacksonville | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST Felix MIDDLE Miguelino LAST Miguelino | | 15. MOTHER'S MAIDEN NAME
FIRST Margarita MIDDLE Alaman LAST Alaman | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
578 52 4916 | | 17. INFORMANT
Same as above
Eusebia Miguelino (Wife) |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Inf
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
None | | | | |
| 19a. DATE OF OPERATION
None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR 0 A.M. MONTH 11 DAY 28 YEAR 1984 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION
STREET 1919 Seminary Road CITY OR TOWN S.S.Md. COUNTY S.S. STATE MD. | |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | |
| ACTUAL SIGNATURE
John S. Rogers, MD | | TITLE (SPECIFY)
MD | | DATE
Dec 28/1984 |
| EXAMINER'S NAME (TYPE OF PRINT)
John S. Rogers, MD | | ADDRESS
1919 Seminary Road S.S.Md. | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
1/2/85 | 23c. NAME OF CEMETERY OR CREMATORY
Arlington Cemetery | 23d. LOCATION
CITY OR TOWN Arlington COUNTY Va. STATE Va. | |
| 24. FUNERAL DIRECTOR
NAME Hines/Rinaldi ADDRESS 11800 New Hamp. Ave. S.S. Md. | | 25a. DATE REC'D. BY REGISTRAR
JAN 3 1985 | | 25b. REGISTRAR'S SIGNATURE
John Davidson |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



1241

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

34099
REG. NO.

~~1 - FOR~~
STATE
REGISTRAR

| | | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Russell I. Miles | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 3, 1984 | | | 2b. HOUR
P M
1:52 P | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 6, 1921 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63
YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
0 0 0 0 | | IF UNDER 24 HRS.
HOURS MIN.
0 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County
MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Civil Service | | | 12b. KIND OF BUSINESS OR INDUSTRY
Dept. of Def. | | | |
| 13a. STATE
Maryland | | | | | | 13b. CITY OR TOWN
N Howard | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS
7379 Brown Bridge Rd. 20759 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
LLOYD MILES | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
RUTH BROWN | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII | | 17. INFORMANT
Helen V. Miles | | ADDRESS
same as #13 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>gastrointestinal hemorrhage</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>embolus of the liver</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>alcoholism</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
48 hours
4 years | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
- | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 3, 1980</u> , to <u>Dec 3, 1984</u> , that (I) (we) last saw the deceased alive on <u>Dec 3, 1984</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
Edward P. Taubman
DEGREE
Attending Physician | | | | | | | | 22c. DATE SIGNED
12/3/84 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Edward P. Taubman | | | | 22e. ADDRESS
1811 Prince Philip Dr., Olney, Md. 20901 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/6/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Zion Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Fulton, Howard, Md. | | | | | | |
| 24. FUNERAL DIRECTOR
FLECK FUNERAL HOME, INC.
7601 Sandy Spring Rd. Laurel, Md. 20707 | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 5 1984 | | 25b. REGISTRAR'S SIGNATURE
Schia Davidson-Randall | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP.



CHIEF EXAM

20X2 COTTON



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO.
34100 | |
|--|--|--|--|--|--------------------------|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR | |
| I. DECEASED NAME (TYPE OR PRINT) | | | | | MONTH DAY YEAR | | | | | HOURS MIN. | |
| CAREL M. MILLER | | | | | 12-19-84 | | | | | 9:35 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Female | | white | | Sept 25, 1926 | | 58 | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Washington, D.C. | | U.S.A. | | | | MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Bethesda MD | | Suburban Hospital | | | | | | | | Retail Sales | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS / ZIP CODE | | | | | | | | | |
| | | 4506 Avondale St. #6 20814 | | | | | | | | | |
| 13b. STATE | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | | | |
| Md. | | Montgomery | | Bethesda | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 4506 Avondale St. #6 20814 | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| FIRST MIDDLE LAST | | | | | FIRST MIDDLE LAST | | | | | | |
| Francis Girard Miller | | | | | Carel Margaret Hasson | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| No | | | | | None | | Md. 20877 | | | | |
| | | | | | 215-26-2959 | | Jean Balzer-sister 102 Cedar Ave Gaithersburg, | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cardio-Pulmonary Arrest | | | | | | | | | | 5' 30" | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) Advanced recurrent Coronary Arteriosclerosis | | | | | | | | | | 7 yr. | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) Inoperable Coronary Arteriosclerosis | | | | | | | | | | 11 yr. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| | | | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | |
| AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/15, 1984, to 12/19, 1984, that (I) (we) lost saw the deceased alive on 12/19, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | |
| J. R. Thistlethwaite | | | | | | | | 12/19/84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| J. R. Thistlethwaite | | | | 10401 Old Georgetown Rd. BETHESDA | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| Cremation | | | | 20 December 1984 | | Lee's Crematory | | Washington, D.C. COUNTY 20002 STATE | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Gartner-Sandison Funeral Home 316 E. Diamond Ave Gaithersburg, Md. | | | | | | | | J. R. Thistlethwaite | | | |

BP

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> </div> <div style="text-align: center; font-weight: bold; font-size: 1.2em;">CERTIFICATE OF DEATH</div> | | | | | | | | | | | |
|--|--|---|---|---|--|--|--|---|---|--|--|
| 1. DECEASED-NAME
<small>(Type or print)</small>
<div style="display: flex; justify-content: space-between;"> First
ROBERT Middle
B Last
MILLER </div> | | | | 2a. DATE OF DEATH
12 Month 8 Day 84 Year | | | 2b. HOUR
7:30 <small>a</small> M | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
Oct. 19, 1905 | | 6. AGE (In years last birthday)
79 YRS. | | IF UNDER 1 YEAR
<small>MONTHS DAYS</small> | | IF UNDER 24 HRS.
<small>HOURS MIN.</small> | |
| 7a. BIRTHPLACE (State or foreign country)
GA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
3632 Glen Eagle Dr. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Ass't. Vice President | | | 12b. KIND OF BUSINESS OR INDUSTRY
C&P Telephone | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MD | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
3632 Glen Eagle Dr. 20906 | | |
| 14. FATHER'S NAME First Middle Last
Ruben Boyd Miller | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Lois A. Bullard | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
<small>(Yes, no, or unknown) (If yes give war or dates of service)</small>
No | | | 16b. SOCIAL SECURITY NO.
212-10-0664 | | 17. INFORMANT Address
Clyde A. Miller 3436 Skyview Terr. 22042 Falls Ch. VA | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure
DU TO, OR AS A CONSEQUENCE OF
(b) Multiple Myocardial Infarctions
DU TO, OR AS A CONSEQUENCE OF
(c) Atherosclerotic Cardiovascular Disease | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
months
years
years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
<small>(If either, notify medical examiner)</small> | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July</u>, 19<u>84</u>, to <u>Dec</u>, 19<u>84</u>, that (I) (we) last saw the deceased alive on <u>Dec</u>, 19<u>84</u>, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Roger F. Leonard MD DEGREE | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
12/9/84 | | |
| 22d. PHYSICIAN'S NAME (Type) Roger F. Leonard, M.D. | | | | | | 22e. ADDRESS
10401 Old Georgetown Rd. Beth., MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | | 23b. DATE
12/1/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | | 23d. LOCATION (City or Town) (County) (State)
Suitland, MD | | | |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. ADDRESS
5130 WI Ave. NW Wash, DC 20016 | | | | | | 25a. REC'D BY REGISTRAR
DEC 17 1984 | | | 25b. REGISTRAR'S SIGNATURE
 | | |

25a. REC'D BY REGISTRAR
DATE **DEC 17 1984**

25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall

Miller

5

1000 1000 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR STATE REGISTRAR | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | 34102
REG. NO. | |
|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Mary B. Millings | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 16, 1984 | | 2b. HOUR
M | |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
July 16, 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S. C. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Olney | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
None |
| 13a. STATE
Md. | | 13b. COUNTY
Mont | 13c. CITY OR TOWN
Silver Spring | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Louis Emerson | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sallie Hall | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
579-10-3418-N | | 17. INFORMANT
Mrs. Marjorie Hunter/daughter/same as 13e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) acute myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) arteriosclerotic heart disease
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
united
years | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Congestive heart failure, garter, aortic aneurysm | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1975 , 19____, to 12-16-84 19____, that (I) (we) lost saw the deceased alive on 11-18-84 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Jeremy V. Cooke | | DEGREE
MD | | 22c. DATE SIGNED
December 17, 1984 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Jeremy V. Cooke | | 22e. ADDRESS
10400 Connecticut Avenue, Kensington, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12-22-84 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood, Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
John T. Rhines Co., 3015 12th St. N.E.D.C. | | ADDRESS
2001 | | 25a. DATE REC'D. BY REGISTRAR
DEC 20 1984 | |
| | | 25b. REGISTRAR'S SIGNATURE
Lia Davidson-Randall | | | |

BP

Billings

B.

July

Black

Female

Montgomery County

Montgomery General Hospital

Olney

December 17,
1984

10400 Connecticut Avenue, Kensington, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|--|--|-------------------|--|--|--|------------------------------|--|
| 1. FOR STATE REGISTRAR | | 3 4 1 0 3 | | REG. NO. | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | | | | | |
| Alyne MacDowell Mitchell | | | | 12/17/84 | | | | | | | | 8:30 A.M. | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | | | |
| Female | | Caucasian | | 3/19/88 | | 96 YRS. | | MONTHS | | DAYS | | HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| Virginia | | U.S.A. | | | | Montgomery MD. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Damascus | | 10908 Longmeadow Drive, Damascus | | | | Homemaker | | Home | | | | | | | | | |
| 13a. STATE | | | | | | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Maryland | | | | | | | | | | Montgomery | | Damascus | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 10908 Longmeadow Drive 20872 | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | |
| Wilbur C.S. MacDowell | | | | Emily Jesse Morton | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | | | | | |
| No | | | | 578-22-9028 | | Emily Lamborn. 3750 Jocelyn St., N.W. Wash. D.C. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| IMMEDIATE CAUSE (a) Cerebrovascular accident | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | |
| Coronary Artery Disease Hypertension Cerebral Vascular Failure | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION | | | | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-12-83 to Present 12-17-84, that (I) (we) last saw the deceased alive on 10-5-84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | | | | | | | |
| John Kijak, M.D. | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 12-17-84 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | | | | | | | |
| John Kijak, M.D. | | | | 9815 Main Street, Damascus, Maryland 20872 | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | | | | | |
| Burial | | | | 12/20/1984 | | Hollywood Cemetery | | | | CITY OR TOWN COUNTY STATE | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE RECD. BY REGISTRAR | | | | | | | | | | | | | |
| Joseph Gawler's Sons Inc. | | | | DEC 24 1984 | | | | | | | | | | | | | |
| 5130 Wisc. Ave., N.W. Wash., D.C. | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | |
| | | | | Gina Lamborn-Randall | | | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|-------------------------------|--|------------------|--|--------------------------------------|--|------|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| Richard J. Mitchell | | | | | | | | 12-04-1984 | | | | | | | | 8:45 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. UNDER 1 YEAR | | 8. UNDER 24 HRS. | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Male | | Caucasian | | July 18, 1899 | | 85 YRS. | | | | | | Montgomery | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| Ohio | | U.S.A. | | | | Montgomery | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Bethesda | | Suburban Hospital | | Consultant | | U.S. Gov't. | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| D.C. | | Washington | | Washington | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 3335 Rittenhouse Street, N.W. | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| Minor Morris Mitchell | | Nannie L. McMahon | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| No | | 170-01-9158 | | Mrs. Winifred Clinton, Same as #13 | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | Cardiac Arrest, Asystole | | Immediate | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | (b) | | Acute Myocardial Infarction | | Immediate | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | (c) | | Coronary Heart Disease | | Unknown | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | Prostate Cancer | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | | | | | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | STREET | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from | | December 1979 | | to | | Dec. 4, 1984 | | that (I) (we) lost | | | | | | | | | |
| saw the deceased alive on | | Nov. 15, 1984 | | and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | | | | | | | | | |
| Thomas C. Havell | | M.D. | | 12/4/84 | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | | | | | |
| Thomas C. Havell, M.D. | | 4201 Cathedral Avenue, N.W. | | | | | | | | | | | | | | | |
| | | Washington, D.C. 20016 | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | | | | | | | |
| Burial | | 12/7/84 | | National Memorial Park | | Falls Church, Virginia | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | |
| Joseph Gawler's Sons, Inc., 5130 Wisconsin Avenue, N.W., Washington, D.C. 20016 | | DEC 11 1984 | | Julia K. [Signature] | | | | | | | | | | | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

34105
REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
DOLORES C MORAN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-31-84 | | | 2b. HOUR 7 MIN 15 P.M. | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 27, 1921 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY
None | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE
Maryland | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Gaithersburg | |
| 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS / ZIP CODE
10604 Wayridge Drive 20879 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James Moran | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna Schmidt | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
197 16 6960 | | 17. INFORMANT
Friend
ADDRESS
Sally S. Lannan Same as item 13 | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Respiratory arrest and cardiac arrest**

DUE TO, OR AS A CONSEQUENCE OF

(b) **ACUTE OVERLOAD**

DUE TO, OR AS A CONSEQUENCE OF

(c) **URINARY TRACT INFECTION**

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

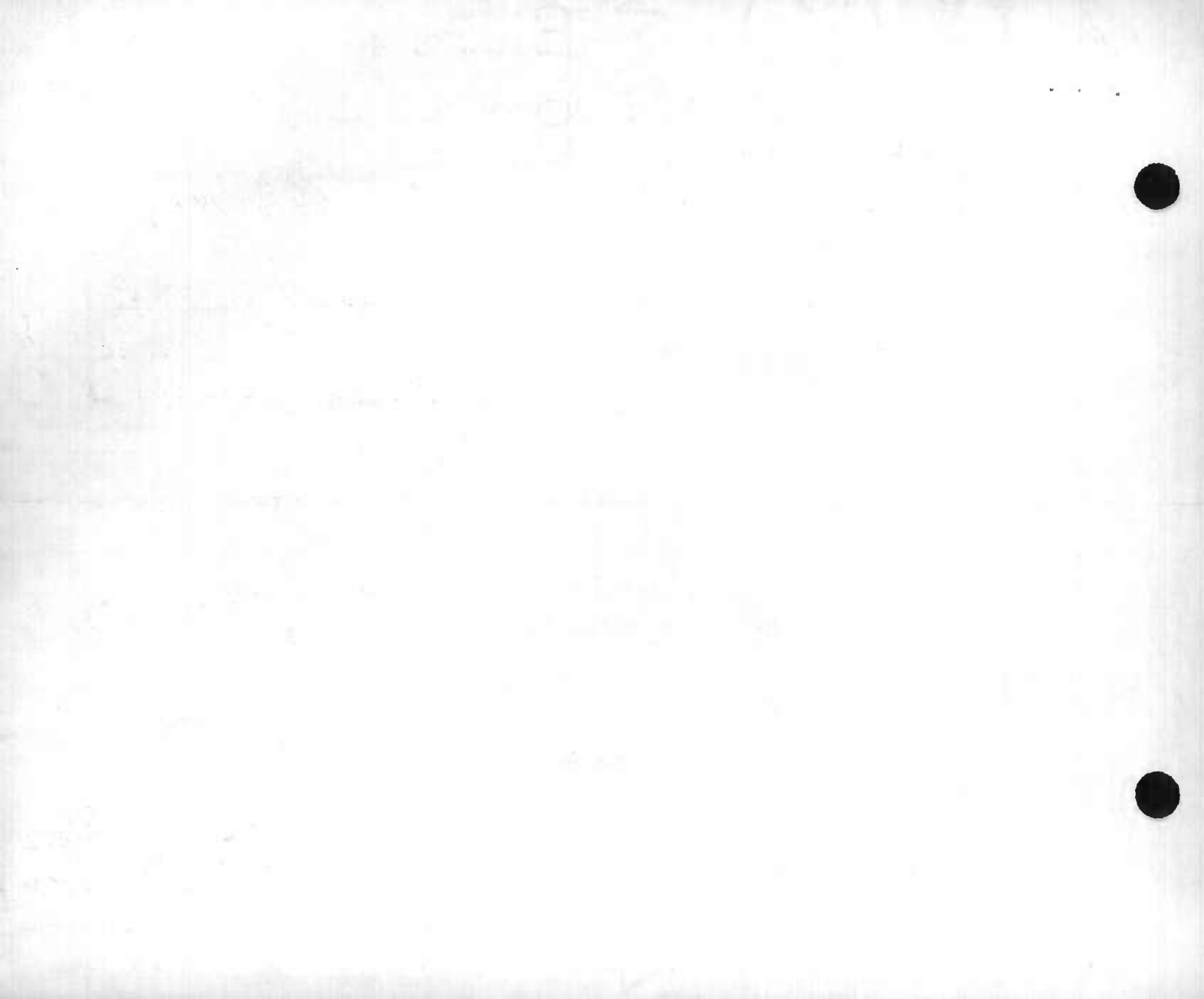
DIABETES MELITUS

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION
19 dec 84 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Colon Bleeding | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 31 dec 84 , 19 84 , to 31 dec 84 , 19 84 , that (I) (we) last saw the deceased alive on 29 dec 84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
K. NOSSULI | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
31 dec 84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
K. NOSSULI | | M.D. | | 22e. ADDRESS
11500 Old Georgetown Rd Rockville, MD 20852 | | | |

| | | | | | | | |
|---|--|----------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
SPECIFY
Burial | | 23b. DATE
Jan. 4, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Hillside Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Roslyn, Pennsylvania | |
| 24. FUNERAL DIRECTOR
NAME
ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 4 1985 | | 25b. REGISTRAR'S SIGNATURE
P. K. Kishner-Pendell | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked, item 4b shows any injury, or other traumatic event, the medical examiner must be notified of once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified by post.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 3 4 1 0 6 | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Matilda Moran | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12/11/84 | | 2b. HOUR
6:10 p.m. | | | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH MONTH DAY YEAR
Jan. 7, 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
National Lutheran Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
at home | |
| 13a. STATE
Maryland | | 13b. CITY OR TOWN
Baltimore | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE
121 Laverne Ave. 21227 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
William George Weber | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Christiana Siehler | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
212-30-4919 | | 17. INFORMANT ADDRESS
Rev. Richard Reichard 9701 Veirs Dr. Rockville, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b)
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: arteriosclerotic Cardio-Vascular Disease | | | | | | | | | |
| 19a. DATE OF OPERATION
— | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
— | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
— P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
— | | | | | |
| 21d. INJURY OCCURRED
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
— | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
— | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 15, 1981 , to Dec. 11, 1984 , that (I) (we) last saw the deceased alive on Dec. 4, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Harold F. McCann, M.D. | | | | DEGREE
M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12-12-84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Harold F. McCann, M.D. | | | | 22e. ADDRESS
3355 16th St. Washington, D.C. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Dec. 14, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Park Cemetery Baltimore, Maryland | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR
The Hysong Co. 1300 N St. N.W. Washington, D.C. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 24 1984 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

4

| | | | |
|----------------|------------------------|--------------|---|
| Female | White | Jan. 7, 1903 | at |
| Maryland | U.S.A. | X | Monetary County |
| Rockville | National Lutheran Home | | Homemaker |
| Maryland | Baltimore | X | 121 Lawrence Ave. |
| William George | Rever | Christians | Shelton |
| no | --- | 212-30-1419 | Rev. Richard Ketchard 2701 Vols Dr. Rockville |

Harold F. Nelson, M.D.
1955 1st St. Washington, D.C.
Baptist
Dec. 1, 1981, Lawrence Park Cemetery Baltimore, Maryland
The State of 1900 N. St. N.W. Washington, D.C. DEC 2 1981

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. If the deceased was 4 months or more pregnant at the time of death, the certificate should be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 34107 | |
|---|--|---|--|---|--|--|---|---|--|---|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
MARY E. MULLIGAN | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
DECEMBER 26, 1984 | | | | 2b. HOUR
10:30 PM | | |
| 3 SEX
Female | | 4 RACE
white | | 5. DATE OF BIRTH MONTH DAY YEAR
July II, 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS
76 | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Oaklahoma | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Chevy Chase | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bethesda Retirement Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
8700 Jones Mill Rd. 20815 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Charles W. Crabtree | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary Cobb | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | | 16b. SOCIAL SECURITY NO.
318-09-7152 | | 17. INFORMANT ADDRESS
T. Elizabeth Pollard 4340 Conn. Ave N.W. D.C. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive Cerebral Thrombosis
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF (c) A . S.H.D. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
23 Days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 3 19 84 to Dec. 26 19 84 , that (I) (we) lost saw the deceased alive on Dec. 23 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE CR Gruver DEGREE | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
12/26/84 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Clifton R. Gruver M.D. | | | | | | 22e. ADDRESS
1445 19th St. N.W. Wash. D.C. 20036 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | | | 23b. DATE
Dec. 29, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Suitland Md. Prince George | | |
| 24. FUNERAL DIRECTOR NAME
Joseph Gawler's sons | | | | | | ADDRESS
5130 Wisc. Ave N.W. D | | | 25a. DATE REC'D. BY REGISTRAR
JAN 3 1985 | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
John Davidson | | | | | |

MEDICAL CERTIFICATION

10:01

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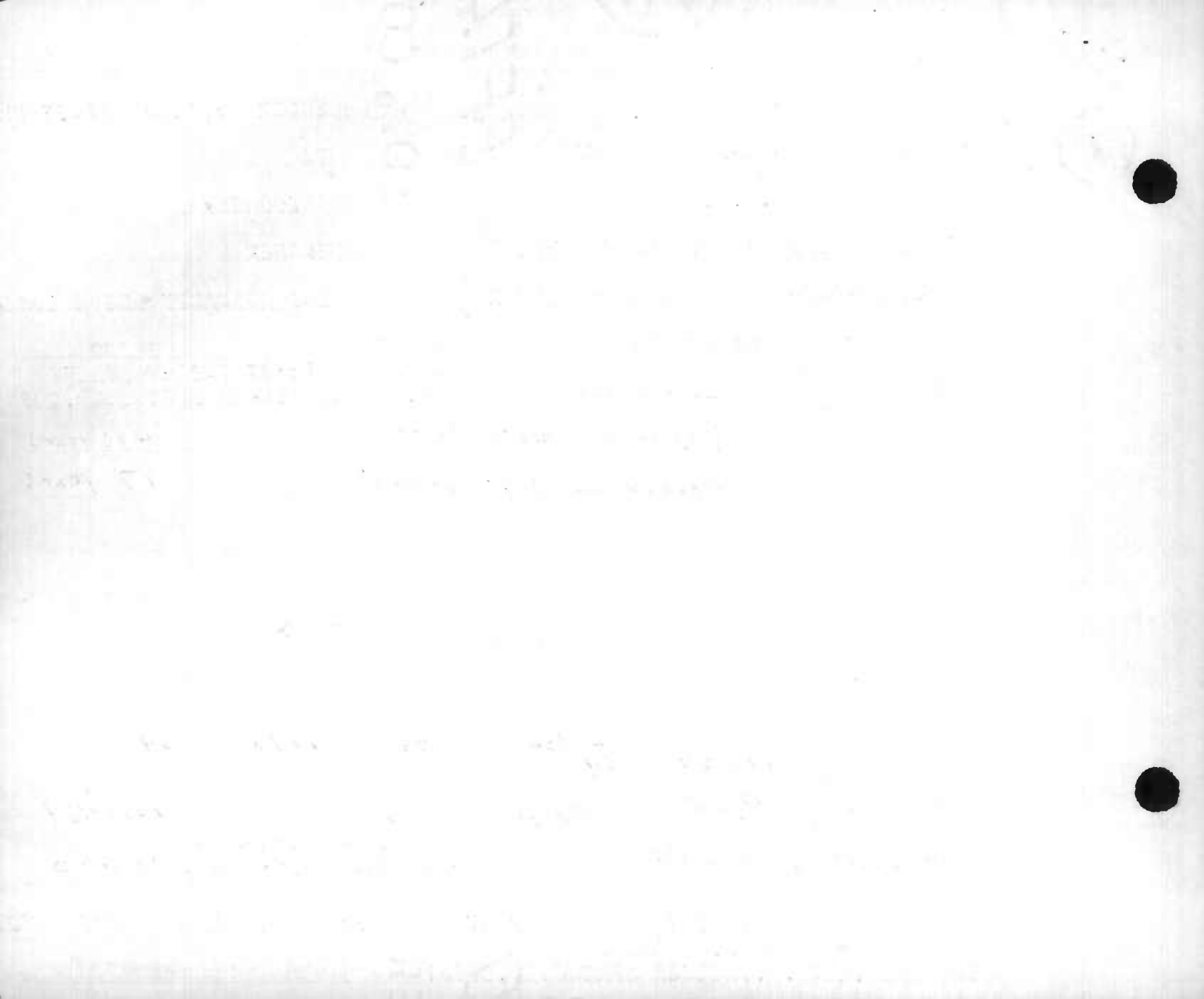
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 4 1 0 8
REG. NO.1- FOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ANGELA G. MYERS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 7, 1984 | | 2b. HOUR
11:07 PM |
| 3. SEX
FEMALE | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH DAY YEAR
MAY 3, 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
10407 INSLEY STREET | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | 13c. CITY OR TOWN
SILVER SPRING | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
206 NORMANDY DRIVE 20901 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
SAVARIO GIRIMONTE | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
PHILOMENA RUSSO | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
417-32-0111 | | 17. INFORMANT
DAUGHTER 10407 INSLEY STREET
ANGELA E. AUDET, SILVER SPRING, MD 20901 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary metastases
DUE TO, OR AS A CONSEQUENCE OF
(b) Carcinoma left breast
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 1/3 years
17 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/20, 1973, to 12/7, 1984, that (I) (we) last saw the deceased alive on 11/27, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Hubert J. Alpert | | | DEGREE
M.D. | | 22c. DATE SIGNED
12/10/84 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HUBERT J. ALPERT, M.D. | | | 22e. ADDRESS
8630 FENTON ST.
SILVER SPRING, MD 20910 | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
12/10/84 | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
SILVER SPRING MONT MD. | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS | | | 25a. DATE REC'D. BY REGISTRAR
DEC 13 1984 | | |
| 500 UNIV. BLVD. W., SILVER SPRING, MD 20901 | | | 25b. REGISTRAR'S SIGNATURE
Lelia Davidson-Randall | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

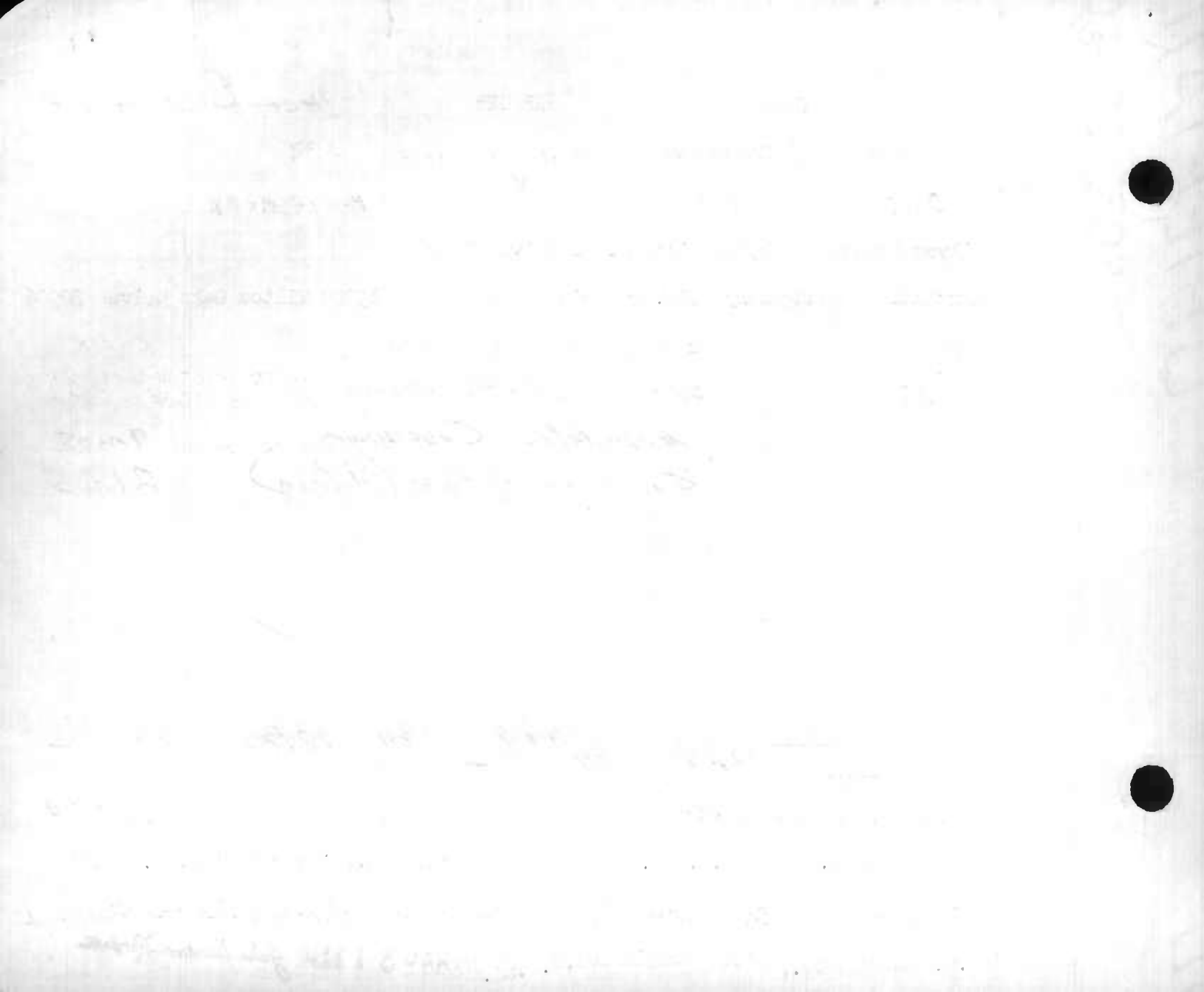
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 34109
REG. NO. | |
|--|--|---|---|---|---|
| 1. FOR STATE REGISTRAR | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
JANE NAFZGER | | | 2a. DATE OF DEATH MONTH DAY YEAR
December 20, 1984 | | 2b. HOUR
11 P.M. |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR
JUNE 8 1945 | 6. AGE (IN YEARS LAST BIRTHDAY)
39 YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
OHIO | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
13009 Wilton Oaks Drive 20906 | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
Maryland | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Silver Spring | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
HARRY BREWSTER | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
DOROTHEA CROCK | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
270-40-4785 | 17. INFORMANT ADDRESS
RICHARD NAFZGER 13009 WILTON OAKS DRIVE SILVER SPRING, MD 20906 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Metastatic Carcinoma
DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Lung (Adeno)
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7 mos
21 mos |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from MAY 19 84 to 12/20 19 84 , that (I) was last saw the deceased alive on 12/17 19 84 , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) was did not view the body after death. | | | | | |
| 22b. SIGNATURE
Lennard G. Gold, M.D. | | DEGREE | | 22c. DATE SIGNED
12/21/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LENNARD G. GOLD, M.D. | | 22e. ADDRESS
8630 Fenton St., Silver Spring, Md. 20910 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
Dec 21, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Chambers Crematory | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE
Riverdale P.G. City Maryland | | 23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE
HEC 3 1 1984 Julia Davidson-Roberts | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS
W.W. CHAMBERS CO., 8655 Georgia Ave, S.S. Md. 20916 | | | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

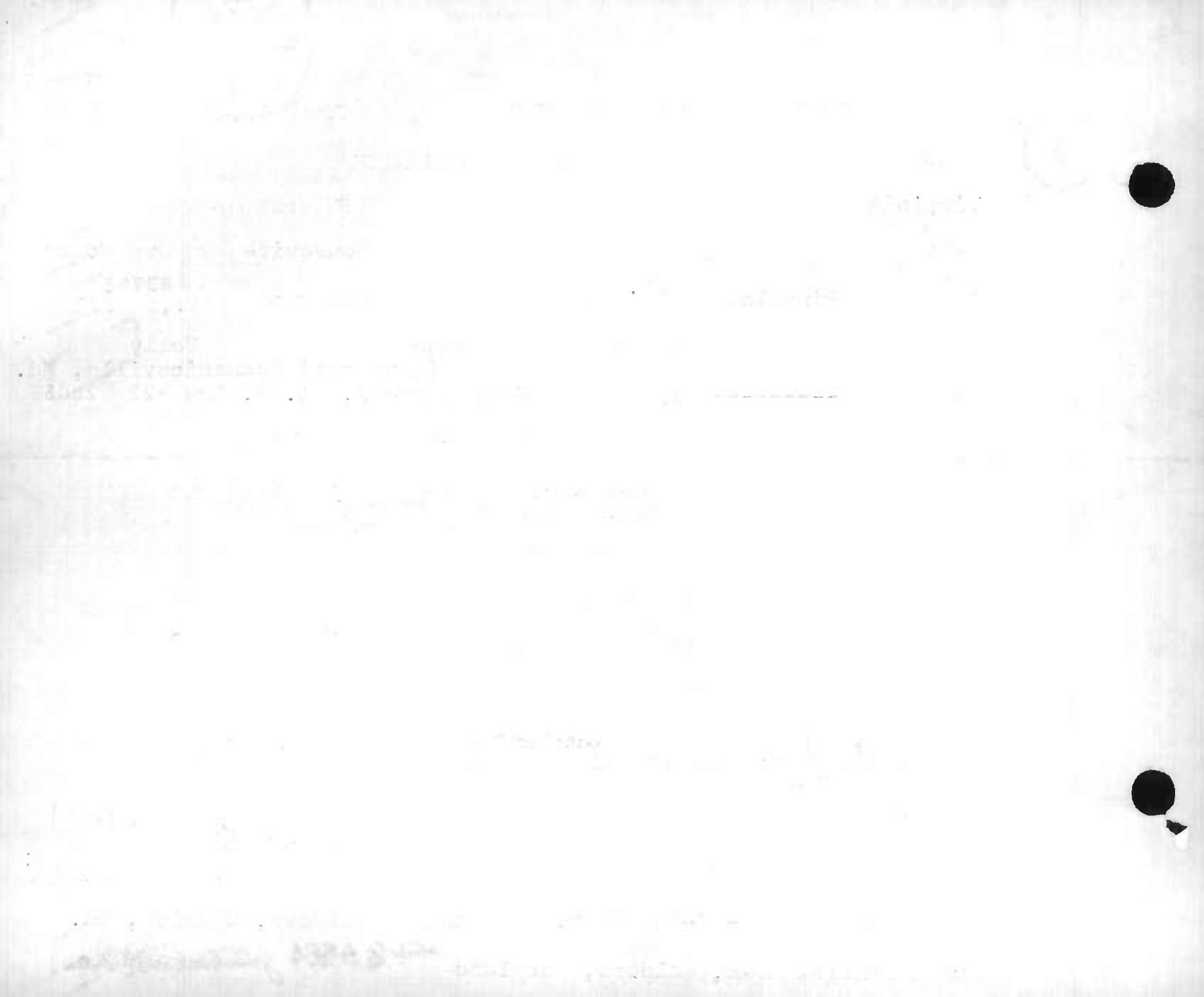
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

34110

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|--|---|---|----------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
RUBY NADINE NEAL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 18, 1984 | | 2b. HOUR
7:30A M | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
NOVEMBER 29, 1930 | | 6. AGE (IN YEARS LAST BIRTHDAY)
54 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NIH, THE CLINICAL CENTER | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 13a. STATE
FLORIDA | | 13b. COUNTY
Pinellas | | 13c. CITY OR TOWN
St. PETERSBURG | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Bowyer | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Gertrude Tolly | | 13e. STREET ADDRESS / ZIP CODE
1500 47th Ave., North 33703 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
231-32-6742 | | 17. INFORMANT (Daughter) ADDRESS
Cindy Norvell, Rt. 4, Box 422 20659 Mechanicsville, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary arrest, cause undetermined
DUE TO, OR AS A CONSEQUENCE OF
(b) Extensive tumor metastasis in liver (more than 90% replacement), bone and lymph nodes in multiple regions.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 30, 1984 to DECEMBER 18, 1984 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on DECEMBER 18, 1984 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Frederic J. Kaye | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/18/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Frederic J. Kaye | | | | 22e. ADDRESS
NATIONAL INSTITUTES OF HEALTH, 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20205 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
12-20-84 | | 23c. NAME OF CEMETERY OR CREMATORY
Huntt Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Waldorf, Charles, Md. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Huntt Funeral Home, Waldorf, Maryland | | | | DATE RECD. BY REGISTRAR DEC 24 1984 REGISTRAR'S SIGNATURE John E. ... | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

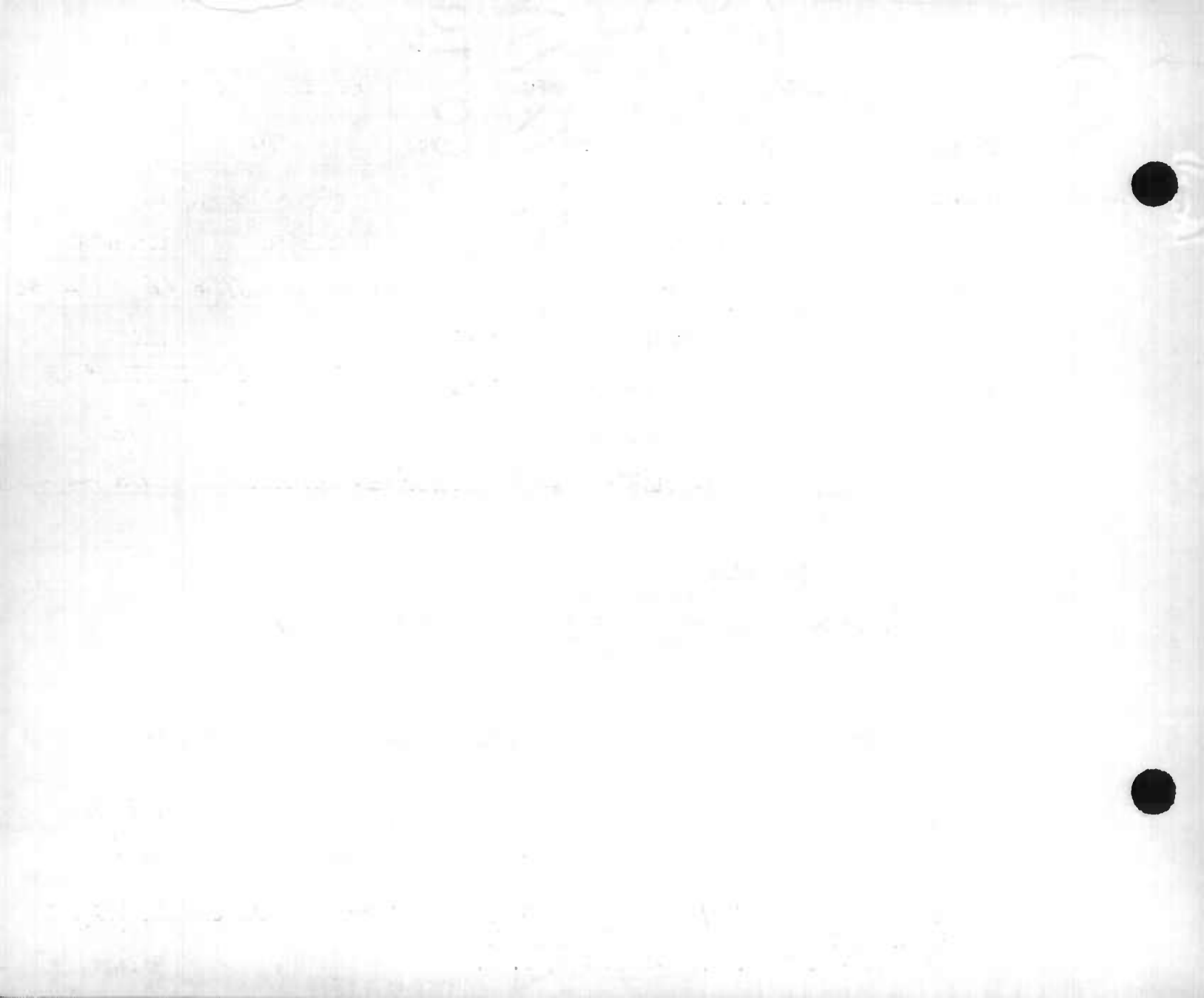
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 4 1 1 1
REG. NO.

1- FOR
STATE
REGISTRAR

| | | | |
|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST SARA MIDDLE NEU LAST NEU
Sara Neu | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 12 24 1984
2b. HOUR
8 26 A M | |
| 3 SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
JUNE 6, 1898 | 6. AGE (IN YEARS LAST BIRTHDAY)
86
UNDER 1 YEAR
MONTHS DAYS
UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
AUSTRIA | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE
12b. KIND OF BUSINESS OR INDUSTRY
OWN HOME |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | |
| 13a. STATE
MD | 13b. CITY OR TOWN
Montgomery | 13c. CITY OR TOWN
Rockville | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
SAM WOHL | | 15. MOTHER'S MAIDEN NAME
MIDDLE LAST
PEARL BRESS | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
579-38-7016 | |
| 17. INFORMANT
ADDRESS
IRVING FALK, 10500 ROCKVILLE PIKE #625
ROCKVILLE, MARYLAND | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Shock
DUE TO, OR AS A CONSEQUENCE OF
(b) Aortic insufficiency / thrombosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1d
1d | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Lower GI Bleeding | | | |
| 19a. DATE OF OPERATION
Angiography
12/23/84 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Lower gastrointestinal bleeding | |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | |
| 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) this hospital attended the deceased from 12/23/84 to 12/23/84, that (2) (we) lost
saw the deceased alive on 12/23/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above (1) (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mm) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz) | | | |
| 22b. SIGNATURE
Peter Sherer MD | | 22c. DATE SIGNED
12/24/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Peter B. Sherer MD | | 22e. ADDRESS
3947 Ferrara Dr. Wheaton, MD | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | |
| BURIAL | | 12/26/1984 | |
| 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| KING DAVID MEMORIAL GARDEN | | FALLS CHURCH, VIRGINIA | |
| 24. NAME OF FUNERAL HOME
(TYPE OR PRINT)
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME
232 CARROLL STREET, N. W., WASHINGTON, D. C. | | 25a. DATE REC'D. BY REGISTRAR
25b. REGISTRAR'S SIGNATURE
John E. ... | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 34112
REG. NO. | |
|---|--|---|--|---|--|--|--|---|--|--|--|
| 1 - FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT)
JERRY DAVID NISWANDER | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
DECEMBER 18, 1984 | | 2b. HOUR
11:45 P | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
MARCH 1, 1930 | | 6. AGE (IN YEARS LAST BIRTHDAY)
54 YRS | | 7a. IF UNDER 1 YEAR MONTHS DAYS | | 7b. IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
IOWA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
CLINICAL CENTER (NIH) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Dentist | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S.P.H. Svc. | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE MARYLAND | | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
DAMASCUS | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
8945 GUE ROAD 20872 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Paul Niswander | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Lucille Arnold | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
277-20-9487 | | 17. INFORMANT ADDRESS
MRS. DEBORAH NISWANDER (WIFE) SAME AS ABOVE | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 MINUTES | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) <u>NECROTIC TUMOR WITH MARKED SWELLING RIGHT TEMPORAL LOBE</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) <u>ASTROCYTOMA (GRADE III - IV)</u> | | | | | | | | | | 2 MONTHS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION
11/11/84 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
ASTROCYTOMA (GRADE III - IV) | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1, OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>November 21, 1984</u> to <u>DEC. 18, 1984</u> , that <input checked="" type="checkbox"/> (we) lost
saw the deceased alive on <u>DEC. 18, 1984</u> , and that in <input checked="" type="checkbox"/> (my) <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated
above, <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Frederic J. Kaye</i> | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
12/19/84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Frederic J. Kaye | | 22e. ADDRESS
NATIONAL INSTITUTES OF HEALTH
CLINICAL CENTER, BETHESDA, MD 20205 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Dec. 21, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Pine Grove | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Mt. Airy, Carroll, Md. | | | | | |
| 24. FUNERAL DIRECTOR
Glen L. Molesworth, P.A., Damascus, Md. | | | | 25. DATE REC'D. BY REGISTRAR
DEC 24 1984 | | 25. REGISTRAR'S SIGNATURE
<i>John L. ...</i> | | | | | |

BP

Nov 2 1943

Palmer

Alford

W. H. H.

W. H. H.

W. H. H.

Nov 2 1943

W. H. H.

W. H. H.

W. H. H.

Nov 2 1943

W. H. H.

W. H. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

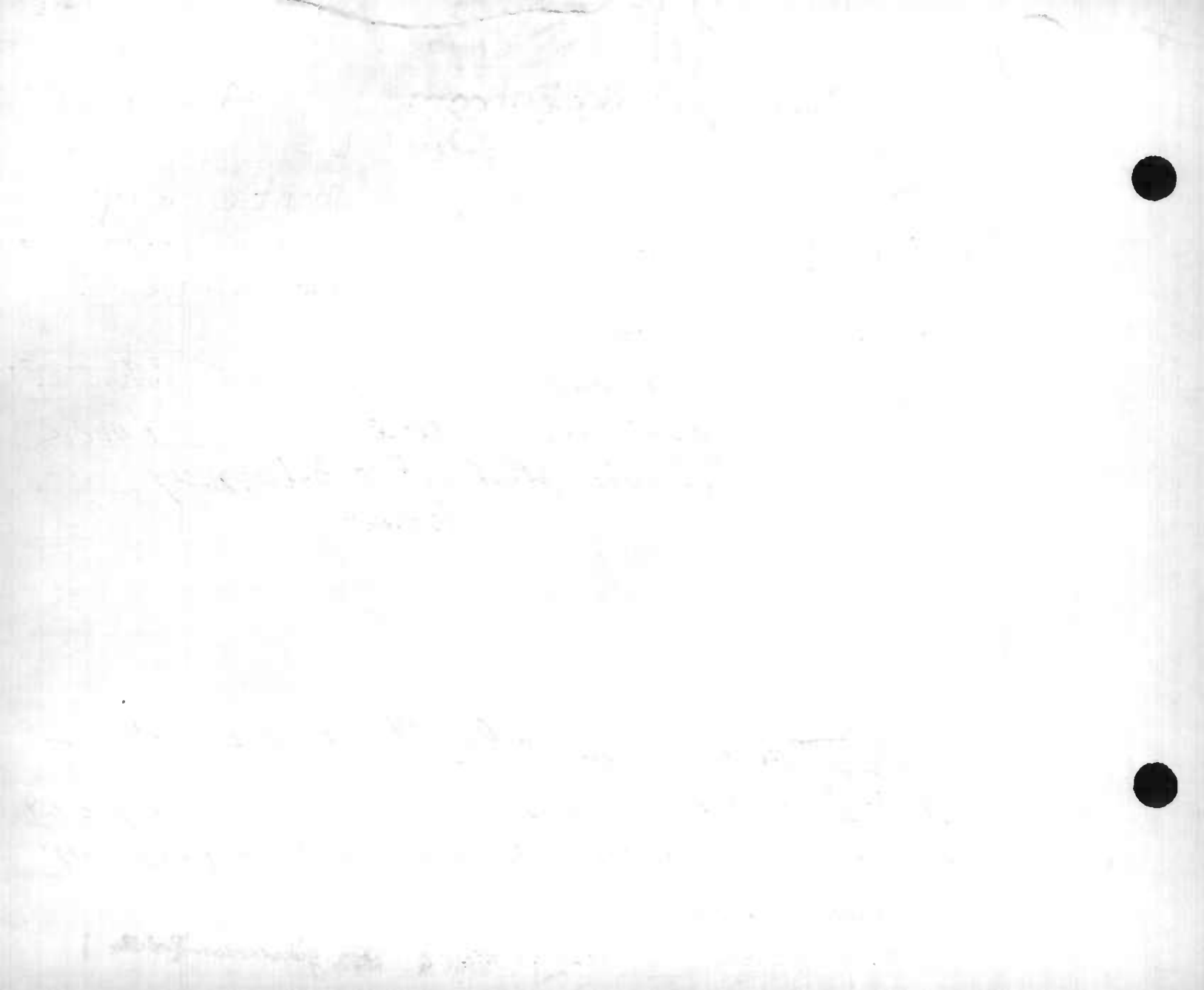
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 4 1 1 3
REG. NO.

| | | | | | |
|--|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Willa Nootenboom | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-27-84 | | 2b. HOUR
1 AM | |
| 3. SEX
Female | 4. RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR
1 23 84 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Beautician | | 12b. KIND OF BUSINESS OR INDUSTRY
Beauty Shop |
| 13a. STATE
Md | 13b. COUNTY | 13c. CITY OR TOWN
Silver Sprg | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
10000 Brunswick Ave. 20910 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Molden | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
579-05-1115 | | 17. INFORMANT
ADDRESS 8408 Spruill Dr.
Mr. Wm. L. Cervenka Bowie, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>pulmonary failure</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>chronic obstructive pulmonary disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 WEEK |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>31 July 84</u> to <u>27 Dec 84</u> , that (I) (we) last saw the deceased alive on <u>26 Dec 84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
WALTER E. GOOZH MD | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
27 Dec 84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
WALTER E. GOOZH MD | | 22e. ADDRESS
2309 SHOREFIELD RD WHEATON MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Removal | | 23b. DATE
12/27/84 | | 23c. NAME OF CEMETERY OR CREMATORY | |
| 24. FUNERAL DIRECTOR
NAME
Anatomy Board | | ADDRESS
Balto., MD | | 25a. DATE REC'D. BY REGISTRAR
JAN 4 1985 | |
| | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|---|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | 34114
REG. NO. | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
Pauline E Oak | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 21 1984 | | | 2b. HOUR
9:45A _M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
March 6, 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY)
91 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Main | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Recreation | | 12b. KIND OF BUSINESS OR INDUSTRY
D.C. Govt. | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montg. | | 13c. CITY OR TOWN
Olney | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Josph Oak | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Catholine Eaton | | 13e. STREET ADDRESS
18430 Brook Grove Rd. 20832 | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
578-26-0340 | | 17. INFORMANT ADDRESS
Gloria E. Sain 3726 Connecticut Ave N.W. Wash. D.C. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary atherosclerosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Pneumonia for self sufficiency, old cardiovascular accident.</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 18</u> 19 <u>84</u> to <u>Dec 21</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>Dec 21</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Ruben Cosca</u> | | DEGREE | | ATTENDING MEDICAL STAFF
PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RUBEN COSCA, M.D. | | 22e. ADDRESS
1737 MEDLAND RD MD
DENWOOD MD 20835 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
May 1, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
South Side Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
SKOWHEGAN Main | | | |
| 24. FUNERAL DIRECTOR
NAME
W.W. Chambers CO INC | | ADDRESS
8655 Georgia Ave
Silver Spring Md. | | 25a. DATE REC'D. BY REGISTRAR
DEC 31 1984 | | 25b. REGISTRAR'S SIGNATURE
John Davidson | | | |

BP

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0456-6272-652

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH 0 43 4 1 1 5
REG. NO.

| | | | | | |
|--|---|--|--------------------------------------|------------------------|--|
| 1. FOR
STATE
REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | MONTH DAY YEAR | | MONTH DAY YEAR | |
| James J. O'Brien | | 12 30 84 | | 7:00 P. M. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YEAR | |
| Male | Caucasian | MONTH DAY YEAR | 60 YRS. | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| PENNSYLVANIA | U.S.A. | | Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Bethesda | Suburban Hospital | WATER RESOURCES | ENG. CIVIL SERV | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | 13b. CITY OR TOWN | 13c. INSIDE CITY LIMITS? | 13d. STREET ADDRESS / ZIP CODE | | |
| MD | Montgomery | Bethesda | 9322 W. Parkhill Dr. 20814 | | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | |
| JAMES J. O'BRIEN | EDNA V. FISHER | YES WW II | | | |
| 16b. SOCIAL SECURITY NO. | 17. INFORMANT | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Carcinoma, Lung, - metastasis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | |
| 190-18-0301 | ATTIYA B. O'BRIEN | SAME AS 13 WIFE | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | |
| 19a. DATE OF OPERATION | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | |
| 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | |
| 21f. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 27</u> 19 <u>84</u> to <u>Dec 30</u> 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>Dec 30</u> 19 <u>84</u> , and that in (my) (an) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Earl Mitchell, M.D.</u> DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | |
| 22c. DATE SIGNED <u>Dec 31 84</u> | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>EARL MITCHELL</u> | | | | | |
| 22e. ADDRESS <u>2023 R ST., N.W., WASHINGTON, D.C. 20009</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>CREMATION</u> | | | | | |
| 23b. DATE <u>1/2/85</u> | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>METROPOLITAN CREMATORY</u> | | | | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE <u>ALEXANDRIA VIRGINIA</u> | | | | | |
| 24. FUNERAL DIRECTOR NAME <u>FRANCIS J. COLLINS</u> ADDRESS <u>500 UNIV. BLVD., W. SILVER SPRING, MD. 20901</u> | | | | | |
| 25a. DATE REC'D. BY REGISTRAR <u>JAN 4 1985</u> REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u> | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 4 1 1 6
REG. NO.

| | | | | | |
|---|---------|---|---------------------------------|--|--|
| 1. FOR
STATE
REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| FLORENCE MILLER OKUN | | December 20, 1984 | | 7:15aM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| Female | White | September 2, 1918 | 66 | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) | | 7b. CITIZEN OF WHAT COUNTRY? | | 7c. BALTIMORE CITY OR COUNTY OF DEATH | |
| NEW YORK | | U.S.A. | | Montgomery COUNTY MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Silver Spring | | Holy Cross Hospital | | GROCER | |
| 13a. STATE | | 13b. CITY OR TOWN | | 13c. STREET ADDRESS | |
| Maryland | | MONTGOMERY Kensington | | 20895
11011 Brandywine Street | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | |
| JOSEPH MILLER | | MINNIE FRISHMAN | | NO | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | |
| 579-03-0353A | | MARTIN L. OKUN, 6 THORBURN PLACE,
GAITHERSBURG, MARYLAND | | PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Congestive heart failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Arteriosclerotic valvular heart d. severe</u> | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) this hospital attended the deceased from <u>12/18</u> 19 <u>84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (2) (did) (did not) view the body after death. | | 22b. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22c. DATE SIGNED | |
| JAMES R. COLEMAN MD. | | JAMES R. COLEMAN | | 12/20/84 | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATOR | |
| BURIAL | | 12/21/1984 | | BETH SHOLOM CONGREGATION
CEMETERY | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME
232 CARROLL STREET, N. W. WASHINGTON, D. C. | | DEC 26 1984 | | J. R. [Signature] | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH 8 4

REG. NO. 3 4 1 1 7

| | | | | | |
|---|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Janet S O'Leary | | | 7a. DATE OF DEATH
MONTH DAY YEAR
12 04 84 | | 7b. HOUR
P. M.
9:35 P. |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
05-14-1898 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS. | |
| 7a. BIRTHPLACE
STATE OR FOREIGN
Virginia | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Stenographer | | 12b. KIND OF BUSINESS OR INDUSTRY
Bureau of Public Roads |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Chevy Chase | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Russell Stevens | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Nettie E. Spencer | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
577-84-6888 | | 17. INFORMANT
ADDRESS
Mr. Charles R. Bostian, Same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
minutes to |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | hours |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
Parkinsons, Alzheimers, 70 Cerebrovascular accident | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb , 19 84 , to Dec 4 , 19 84 , that (I) (we) last saw the deceased alive on Dec 4 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Gary H. Miller M.D. | | DEGREE | | 22c. DATE SIGNED
12/4 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Gary H. Miller | | 22e. ADDRESS
916-1955 NW Wash DC | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | 23b. DATE
12/8/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland, Maryland | | | | | |
| 24. FUNERAL DIRECTOR
Joseph Gawler's Sons, Inc., 5130 Wisconsin Avenue, N.W., Washington, D.C. 20016 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 10 1984 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
v. Davidson Handell | |

THE UNIVERSITY OF CHICAGO
DIVISION OF THE PHYSICAL SCIENCES
DEPARTMENT OF CHEMISTRY

RECEIVED
JAN 10 1955
FROM
J. H. DILLON

TO
DR. J. H. DILLON
1155 S. MICHIGAN AVE.
CHICAGO, ILL. 60605

Dear Sir:
I have the pleasure to acknowledge the receipt of your letter of January 5, 1955, regarding the loan of a copy of your paper, "The Structure of the Methyl Radical," to the Division of the Physical Sciences, University of Chicago. The paper has been forwarded to the appropriate authorities for their consideration.

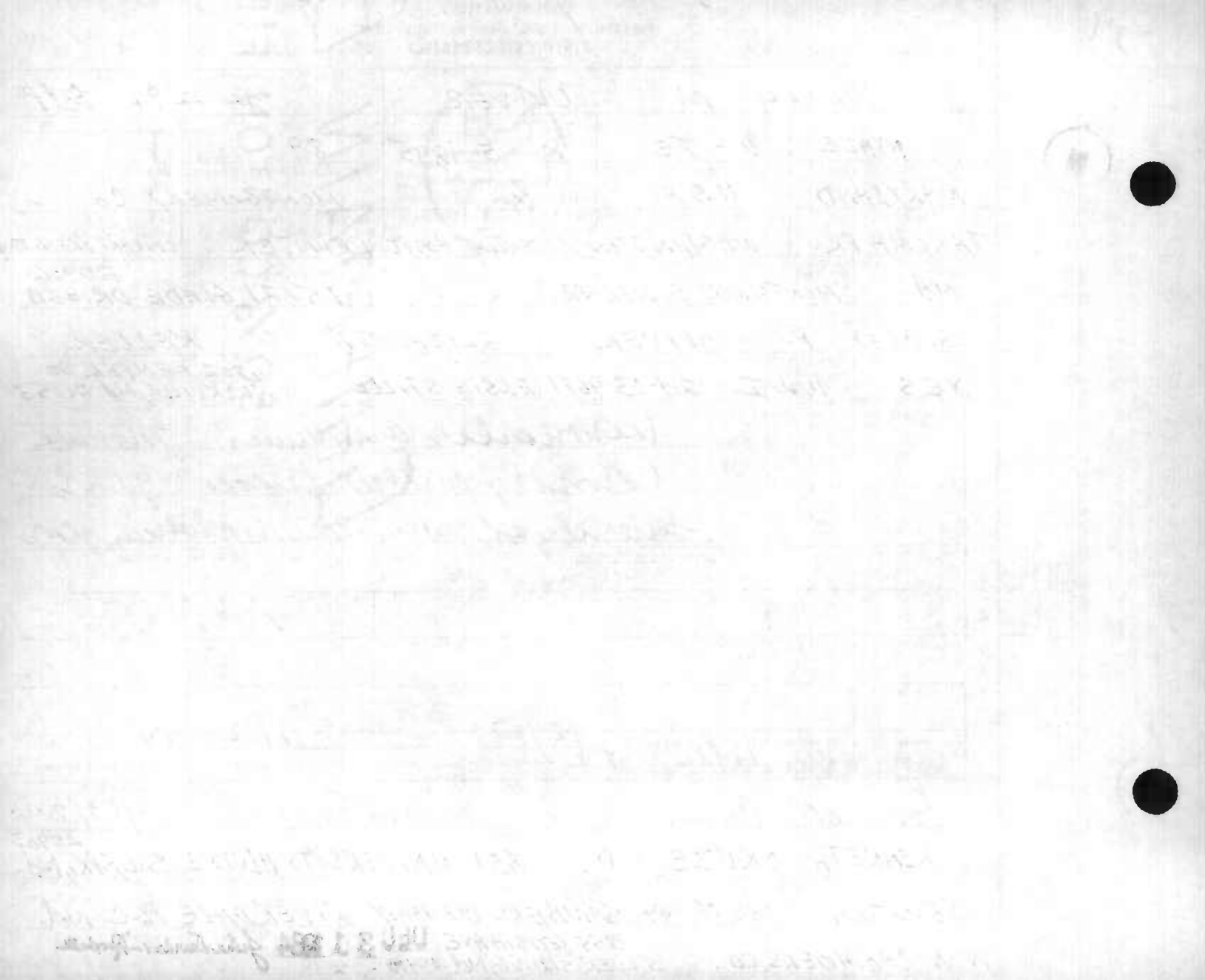
Sincerely,
J. H. DILLON
J. H. DILLON
J. H. DILLON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 3 4 1 1 8
REG. NO. | | 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| FIRST MIDDLE LAST
SIDNEY M OLIVER | | MONTH DAY YEAR
12 22 84 | | MONTH DAY YEAR
12 22 84 | | MONTH DAY YEAR
12 22 84 | | MONTH DAY YEAR
12 22 84 | |
| 3 SEX
MALE | | 4 RACE
WHITE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7 IF UNDER 1 YEAR | |
| MONTH DAY YEAR
8 5 1895 | | MONTH DAY YEAR
8 5 1895 | | MONTH DAY YEAR
8 5 1895 | | MONTH DAY YEAR
8 5 1895 | | MONTH DAY YEAR
8 5 1895 | |
| 7b BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7c CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY CO. MD. | | 10 CITY OR TOWN OF DEATH
TAKOMA PK. | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
WASHINGTON ADVENTIST HOSPT. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
PRINTER | | 12b. KIND OF BUSINESS OR INDUSTRY
COURANT PRESS INC. | | 13a. STREET ADDRESS
15721 GLADE DR. #3B | | 13b. CITY OR TOWN
SILVER SPR. | |
| 14 FATHER'S NAME
SIDNEY P. OLIVER | | 15 MOTHER'S MAIDEN NAME
ELIZABETH KELLER | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES)
YES WWI | | 16b. SOCIAL SECURITY NO.
214-03-9671 | | 17. INFORMANT
ELSIE STILLE | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ventricular arrhythmia</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>coronary artery disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>generalized arteriosclerosis obliterans</u>
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>none</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
minutes | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
years | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
years | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
years | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/17</u> , 19 <u>84</u> , to <u>12/22</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>12/22</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
Kenneth Cruze MD | | 22c. DATE SIGNED
12/23/84 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
KENNETH CRUZE MD. | | 22e. ADDRESS
831 UNIVERSITY BLVD E SILVER SPR, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL
CREMATION | | 23b. DATE
DEC 26, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
CHAMBERS CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
RIVERDALE PGC MD. | | 24. FUNERAL DIRECTOR
W.W. CHAMBERS CO. | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of office.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

34119
REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1- FOR STATE REGISTRAR | | 20I S. PAPADOPOULOS | | 2a. DATE OF DEATH MONTH DAY YEAR 12-5-84 | | 2b. HOUR 8 A.M. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR December 20, 1901 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 82 | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Turkey | | 8. CITIZEN OF WHAT COUNTRY? Turkey | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Potomac | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Stavros Mavropoulos | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria Pyrovolidis | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 217-76-6889 | |
| 17. INFORMANT ADDRESS Julia L. Inglesis, same as # 13 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/4/84 to 12/5/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE Sanford N. Richman, M.D. | | 22c. DATE SIGNED 12/5/84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sanford N. Richman, M.D. | | 22e. ADDRESS 11500 Old Georgetown Rd. Rockville, MD. 20852 | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Dec 8, 1984 | |
| 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland | | 24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes PA | | 25a. DATE REC'D. BY REGISTRAR DEC 10 1984 | |
| 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 34120 | | | |
|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Emile Paul | | | | 2. DATE OF DEATH MONTH DAY YEAR 11 29 84 2b HOUR 9:50 | | | |
| 3. SEX Male | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 4 - 17 - 07 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ENGLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PATENT EXAMINER | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. GOV'T. | |
| 13a. STATE MARYLAND | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN SILVER SPRING | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE 8411 HARTFORD AVENUE 20910 | | 14. FATHER'S NAME (TYPE OR PRINT) ALEXANDER | | 15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) ANNA (UNASCERTAINABLE) | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 219-42-3929 | | 17. INFORMANT MOLLIE S. PAUL | | ADDRESS 8411 HARTFORD AVENUE SILVER SPRING, MARYLAND | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL VASCULAR ACCIDENT.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) ASPIRATION PNEUMONIA.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 WEEK.
2 WEEK. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/29 , 19 84 , to 11/29 , 19 84 , that (I) (we) lost saw the deceased alive on 11/29 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Alan Diamond | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 11/30/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN DIAMOND | | 22e. ADDRESS 1106 SPRING ST SILVER SPRING MD 20910 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL CREMATION | | 23b. DATE 12/1/1984 | | 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND, PR. GEO., MD. | |
| 24. FUNERAL DIRECTOR OR CLERK DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME | | | | 25. DATE REC'D. BY REGISTRAR DEC 05 1984 | | | |
| 232 CARROLL STREET, N. W., WASHINGTON, D.C. | | | | 25b. REGISTRAR'S SIGNATURE Julia Swanson | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 3 4 1 2 1
REG. NO. | |
|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Ruth E PEA BODY</i> | | | | | | December 27, 1984 | | | | 0930h | |
| 3 SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Female | | White | | July 31 1903 | | 81 YRS | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Virginia | | USA | | | | Montgomery MD | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Gaithersburg | | Shady Grove Adventist Hosp | | | | Housewife | | Own Home | | | |
| 13a. STATE | | | | | | 13b. COUNTY | | | | | |
| Maryland | | | | | | Montgomery | | | | | |
| 14. FATHER'S NAME | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| Harding | | | | | | Not Known | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | |
| No | | | | | | 578-40-0186 | | Evelyn Lee | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | | | | 5819 Marlboro Pike #201 Forestville, Md. | | | | | |
| Cardio-Respiratory failure | | | | | | Immediate | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | Respiratory arrest | | | | | |
| (b) | | | | | | " | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | 3 days | | | | | |
| (c) | | | | | | pneumonia | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| Smiling | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2) | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| | | | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) this hospital attended the deceased from <i>Dec 27 1984</i> to <i>Dec 27 1984</i> and that (2) in my own opinion death occurred on the date and hour and from the causes stated | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | |
| <i>Thos G. Ward</i> | | | | MD | | | | 12/27/84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| Thos G. Ward | | | | 6116 Robinwood, Bethesda, Md 20814 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| Burial | | | | 28Dec84 | | Fort Lincoln | | Brentwood PG Md | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Robert E. Wilhelm Funeral Home | | | | | | Suitland, Md | | | | | |

28 JUL 1942

POST BODY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 3 4 1 2 2
REG. NO. | | | |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
GRACE E. PEDDICORD | | | | 2a. DATE OF DEATH MONTH DAY YEAR
December 28, 1984 | | 2b. HOUR
10:10 AM | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
March 5, 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.
84 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
At Home | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
RANDOLPH J. ECKLOFF | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
LAURA JUDD | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
213-74-7402 | | 17. INFORMANT ADDRESS
Herbert R. Peddicord, Jr., Son, S.S.Md. 20910. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardio-resp arrest
DUE TO, OR AS A CONSEQUENCE OF (b) recent acute myocardial infarct
DUE TO, OR AS A CONSEQUENCE OF (c) ASHD with anginal syndrome
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
18 days
9 weeks
20 mo | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
a adhesive intestinal obstruction | | | | | | | |
| 19a. DATE OF OPERATION
11-7-84 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
intest. obstruction | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) hospital attended the deceased from 10-28-84 to 12-28-84 that (1) last saw the deceased alive on 12-27-84 and that in (my) own opinion death occurred on the date and hour and from the causes stated | | | | | | | |
| 22b. SIGNATURE OF PHYSICIAN (TYPE OR PRINT)
George F. Sengstack, M.D. | | | | DEGREE
MD | | 22c. DATE SIGNED
12-28-84 | |
| 22d. ADDRESS
9241 Columbia Blvd., Silver Spring, Md. 20910 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Dec. 31, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Mount Olivet Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Frederick, Frederick Cty., Md. | |
| 24. FUNERAL DIRECTOR NAME
W.W. CHAMBERS CO., 8655 Georgia Ave., S.S. Md. 20910 | | | | 25a. DATE REC'D. BY REGISTRAR
460 3 1 1984 | | 25b. REGISTRAR'S SIGNATURE
John T. ... | |

BP



[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 4 1 2 3
REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|---|---|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Julian C Peterson</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>12 20 84</i> | | | 2b. HOUR
<i>8pm</i> | | | |
| 3 SEX
<i>Male</i> | | 4. RACE
<i>Caucasian</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>01 03 08</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>76</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Nebraska</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Suburban Hospital</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Leasing</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Construction</i> | |
| 13a. STATE
<i>MD</i> | | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Rockville</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>unavailable</i> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>May Frasier</i> | | | 13e. STREET ADDRESS / ZIP CODE
<i>199 Rollings Ave, Rockville 20858</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>no</i> | | | 16b. SOCIAL SECURITY NO.
<i>505-07-0612</i> | | 17. INFORMANT
ADDRESS
<i>John B. Christian 1521 35th St. N.W. Wash., D.C.</i> | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *Pulmonary Embolus*

DUE TO, OR AS A CONSEQUENCE OF

(b) *Vascular Thrombosis*

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
immediate

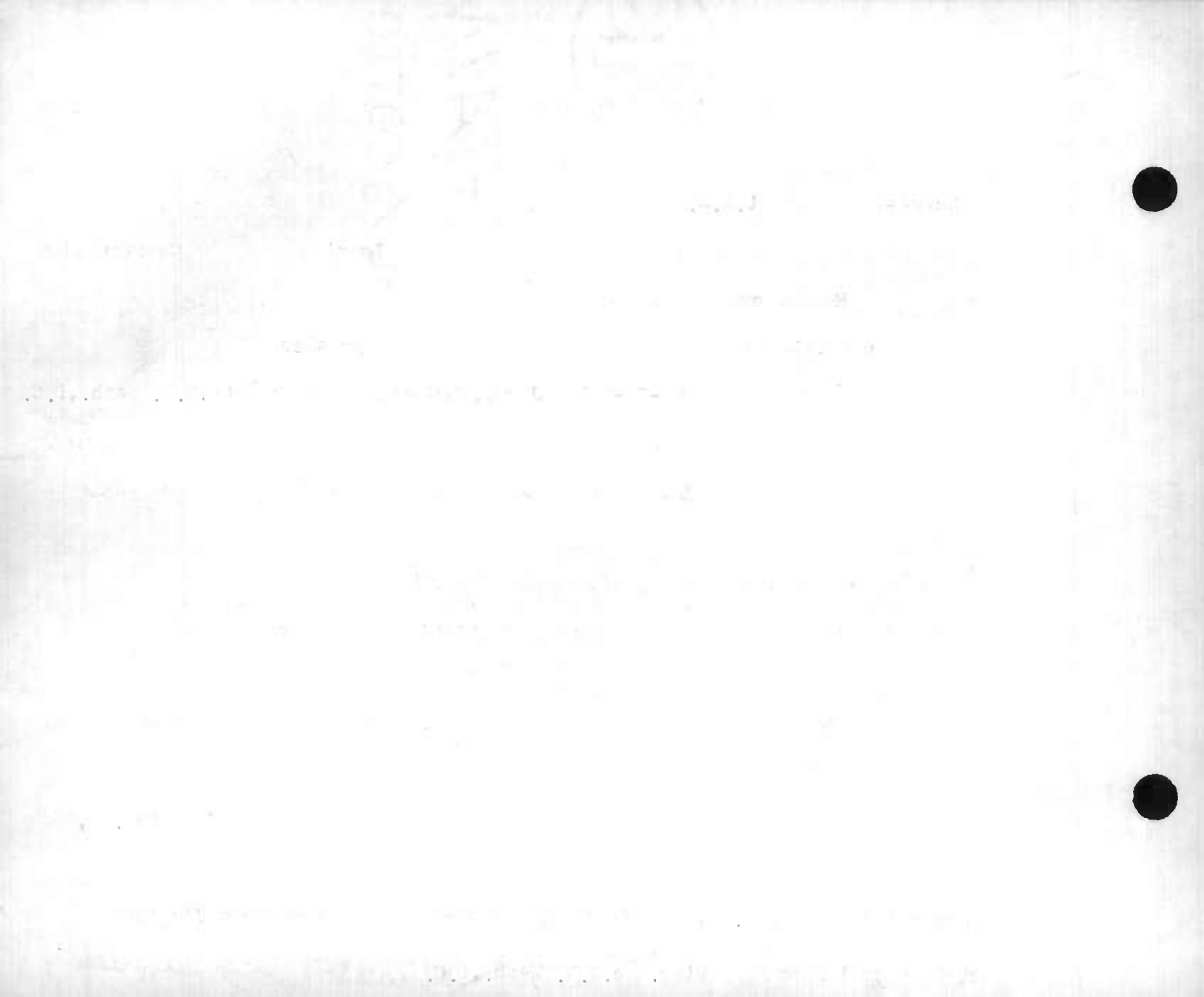
uncertain

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Vascular necrosis of small bowel and feet

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 19a. DATE OF OPERATION
<i>11/23/84</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Terminal Ileum Necrosis</i> | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
<i>Uncertain</i> | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
<i>Home</i> | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
<i>199 Rollings Ave Rockville Mont. Co. MD</i> | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11-22</i> 19 <i>84</i> , to <i>12-20</i> 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>12/20</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Donald Powers MD</i> | | | | DEGREE
<i>MD</i> | | 22c. DATE SIGNED
<i>Dec. 20, 1984</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |

| | | | | | | | |
|--|--|-----------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Cremation</i> | | 23b. DATE
<i>Dec. 23, 1984</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Metropolitan Crematory</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Alexandria Virginia</i> | |
| 24. FUNERAL DIRECTOR
NAME
<i>John F. DeVol</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>DEC 28 1984</i> | | | |
| 25b. REGISTRAR'S SIGNATURE
<i>John F. DeVol</i> | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

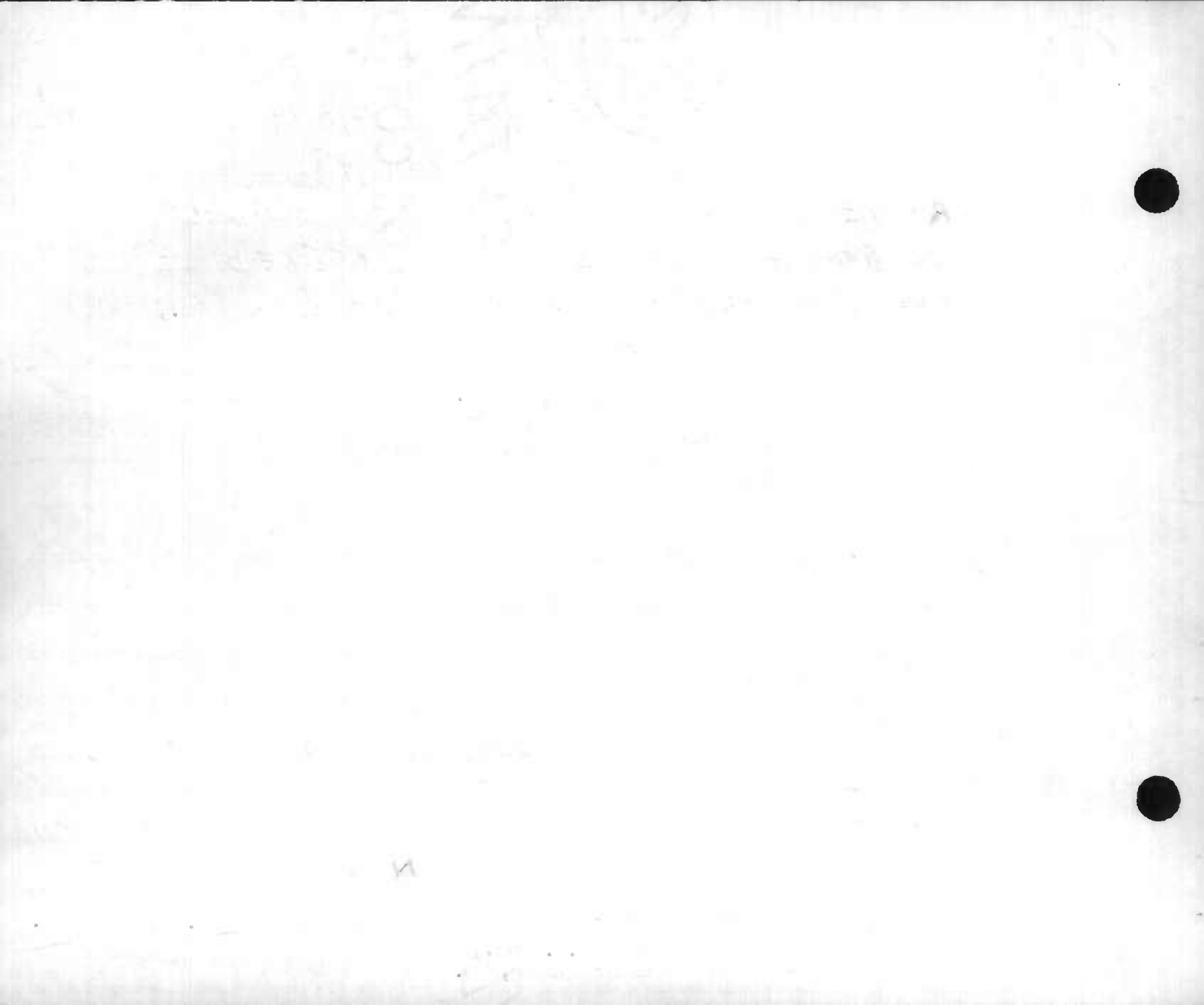
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

64

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 34124 | |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
PETER P PETRYK- | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12/3/84 | | 2b. HOUR P
7:40 M | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
7 12 86 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
98 | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
UKRAINE | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY
Store Keeper | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1121 Cresthaven Dr., 20903 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Paul | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
(unknown) | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
N/A | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OF DATES)
N/A | | 17. INFORMANT
Irena R. Stawnychy-daughter-(same as 13e) | | ADDRESS | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive Cerebral thrombosis
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 3 1984, to Dec 3 1984, that (we) last saw the deceased alive on Dec 3 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
G B Cusher | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12/4/84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
G B Cusher | | 22e. ADDRESS
11161 Newblainshire Ave | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12-6-1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Ukrainian Memorial | | 23d. LOCATION CITY OR TOWN COUNTY STATE
National of USA Suitland Pr. Georges Md. | | | | | |
| 24. FUNERAL DIRECTOR
Hines/Rinaldi Funeral Home | | 11800 N.H. Ave.,
Silver Spring, Md. | | 25a. DATE REC'D BY REGISTRAR
DEC 7 1984 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | | | |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 34125 |
|--|-------------------------|---|--|---|---|--|---|---|--|----------------|
| 1. DECEASED NAME
(TYPE OR PRINT) JAMES JOSEPH PHILLIPS | | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 20 1984 | | 2b. HOUR 1:14A | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR Apr 26 1962 | | 6. AGE (IN YEARS)
LAST BIRTHDAY 22 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR 12 20 1984 | | 2d. HOUR 1:14A | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Oregon | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County | | | |
| 10. CITY OR TOWN OF DEATH
Burtonsville | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Rt 29 South of Patuxent River Bridge | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Active Duty | | 12b. KIND OF BUSINESS OR INDUSTRY
US Navy | | |
| 13a. STATE
Oregon | | 13b. CITY OR TOWN
Oregon City | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
17901 South Edgewood Land | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Roger James Phillips | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Patricia Arlene Gist | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes | | | 16b. SOCIAL SECURITY NO.
541-90-5180 | | 17. INFORMANT
Patricia Phillips 17901 South Edgewood | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple Injuries
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
1:00xx 12/20 1984 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
driver in auto/auto impact | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
roadway | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Rt 29 So of Patuxent Riv Bridge, Mont Co., Maryland | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | |
| ACTUAL SIGNATURE
Gregory R. Kauffman, MD. | | | | TITLE (SPECIFY)
M.D. Assistant | | | | DATE SIGNED
12/20/84 | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | | | ADDRESS
111 Penn Street, Balto, MD 21201 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | 23b. DATE
12-24-84 | | 23c. NAME OF CEMETERY OR CREMATORY
Funeral Service
Lincoln-Williamette | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Portland Oregon | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
MARSHALL FUNERAL HOME 4217 9th St NW Washington, DC | | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Rodell | | | |

93011 MOLLON 6007

QWMD

WIKITHE



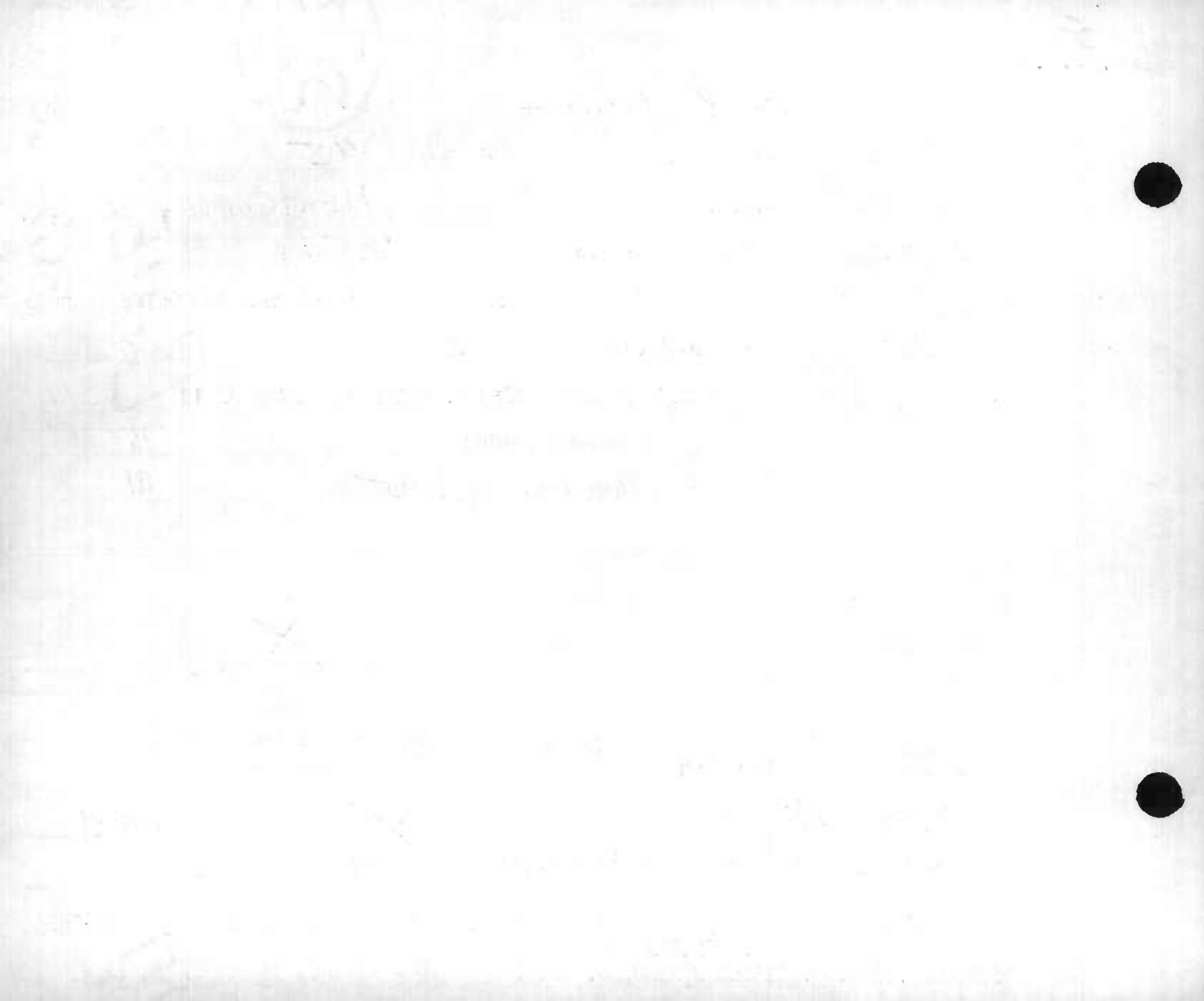
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Patient may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 34126
REG. NO. | |
|---|--|---|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ALICIA P. PILLING | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/15/84 | | | 2b. HOUR
11:27 A.M. | | |
| 3. SEX
FEMALE | | 4. RACE
PHILLIPINO | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 08 39 | | 6. AGE (IN YEARS LAST BIRTHDAY)
45 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | 8. IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PHILLIPINES | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery Co. MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SECRETARY | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
POTOMAC | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
10804 ROCK RUN DRIVE 20854 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
MELCHOR PRODIGALIDAD | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
BETRIZE ONG | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
224-86-3834 | | 17. INFORMANT
JOHN C. PILLING | | | ADDRESS
SAME AS 13 HUSBAND | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) respiratory failure
DUE TO, OR AS A CONSEQUENCE OF (b) carcinoma of breast
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1h
M | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-6 19 84 to 12/15 19 84 , that (I) (we) lost saw the deceased alive on 10/15/84 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Marion D. Welter | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
12/15/84 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARION WELTER | | | | | | 22e. ADDRESS
1515 Greenway Cir Dr Greenbelt MD 20710 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | | | | 23b. DATE
12/18/84 | | 23c. NAME OF CEMETERY OR CREMATORY
METROPOLITAN CREMATORY | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ALEXANDRIA VIRGINIA | | |
| 24. FUNERAL DIRECTOR
NAME FRANCIS J. COLLINS ADDRESS
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
DEC 19 1984 Julia Davidson Randall | | | | | |

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

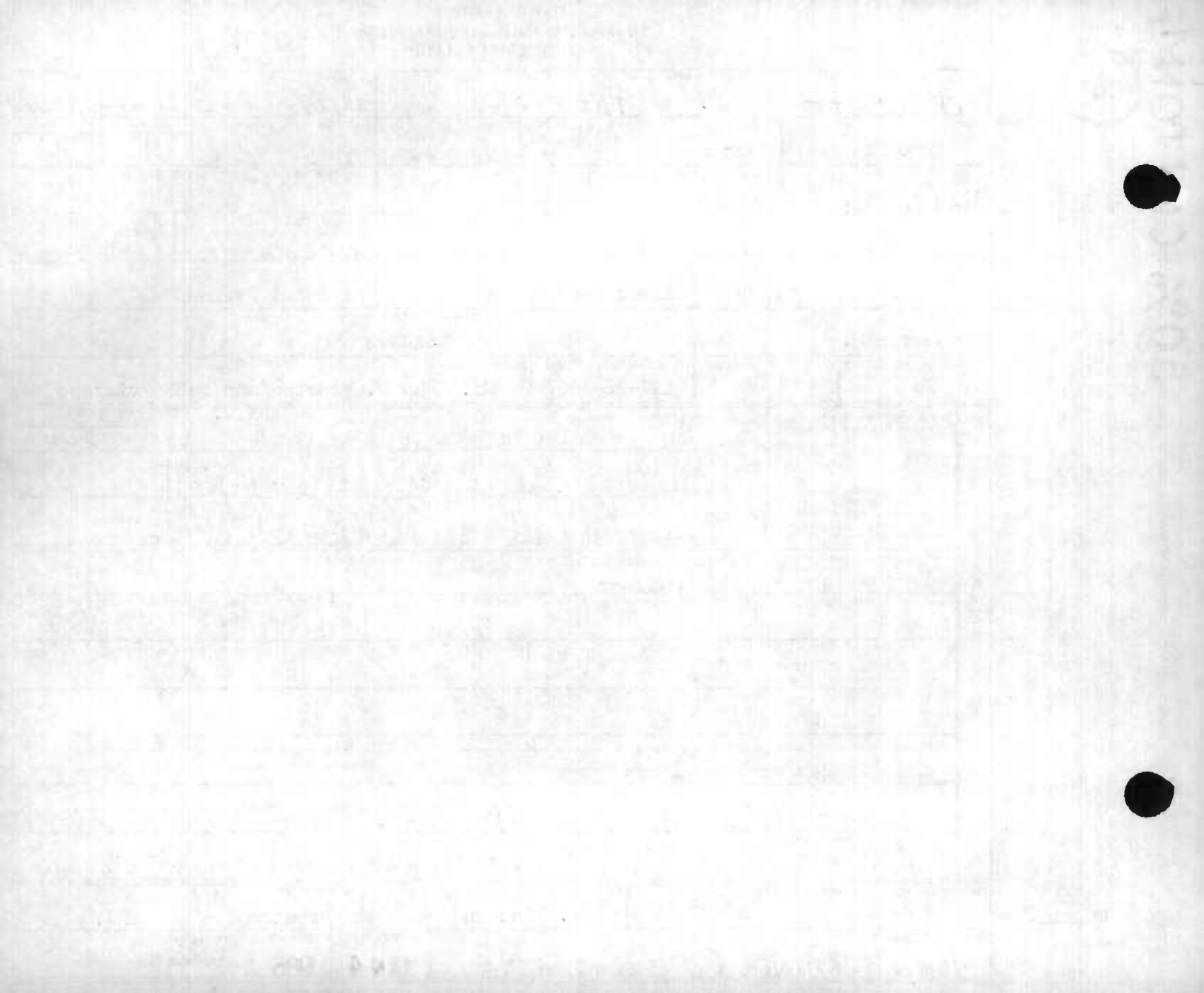
1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

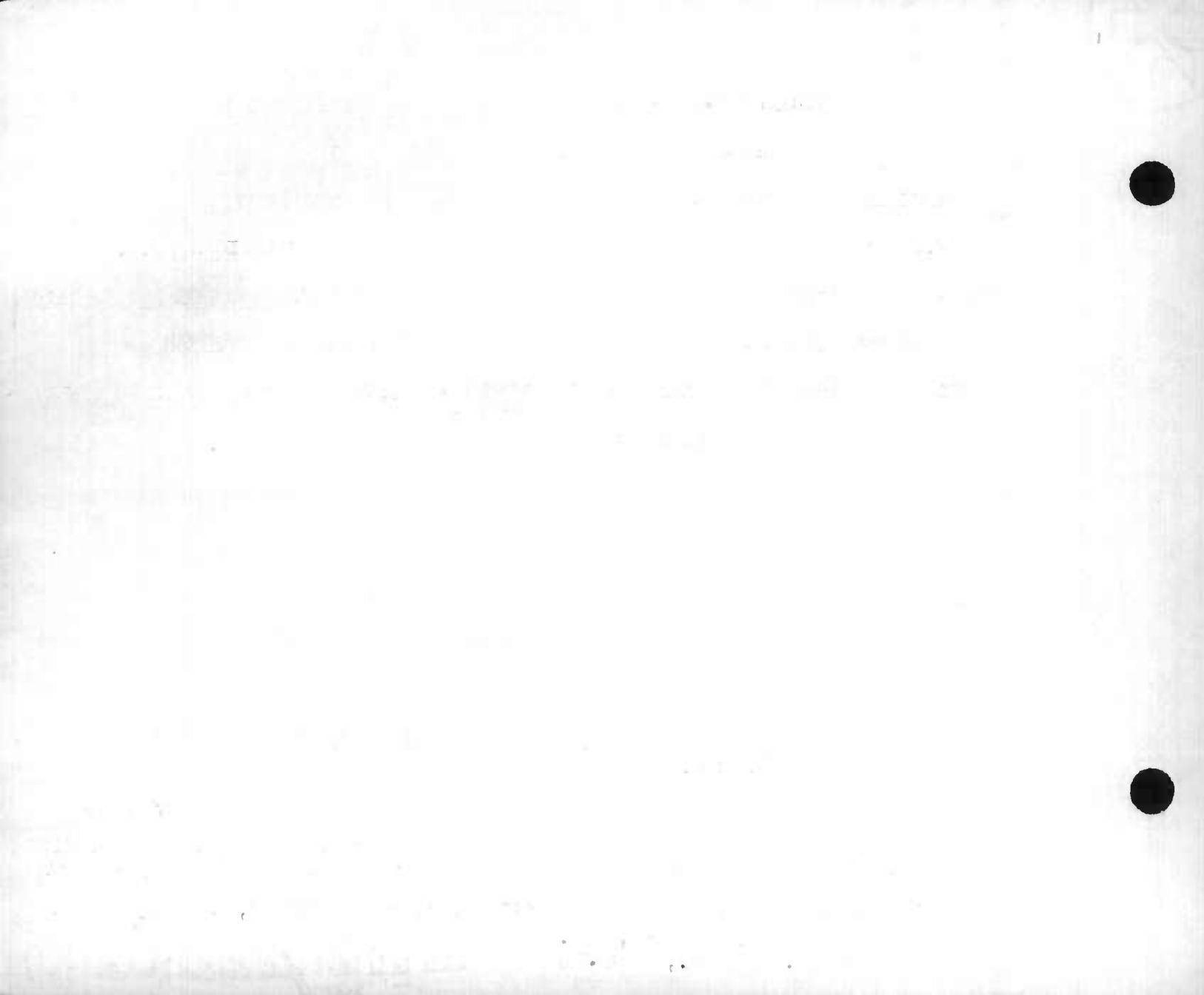
REG. NO.

34127

| | | | | | | | | | |
|---|--|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
JEWETT L. PRESTON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/20/84 12 20 84 | | | 2b. HOUR
3:20 PM | | | |
| 3 SEX
Female | | 4 RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
7 30 94 | | 6 AGE (IN YEARS LAST BIRTHDAY)
90 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
BALT. Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Mont MD. | | | |
| 10 CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MCARRIAGE HILL NURSING HOME | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOME MAKER | | 12b. KIND OF BUSINESS OR INDUSTRY
None | |
| 13a. STATE
Md. | | 13b. COUNTY
Mont | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
9101 2nd Avenue 20910 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George M. Lane | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
117-36-6937 | | 17. INFORMANT
ADDRESS
Mr. John H. Preston/son/1655 Primrose Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Cardiorespiratory failure
DUE TO, OR AS A CONSEQUENCE OF (b) Bleeding Esophageal Varices, Chronic Hepatitis
DUE TO, OR AS A CONSEQUENCE OF (c) Probably long standing carcinoma of wall with metastasis
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
14 days | | | | | | | | N.W. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Portal Hypertension | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-6- 19 84 , to 12-18- 19 84 , that (I) (we) last saw the deceased alive on 12-18- 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
E.T. CARRENO | | | | DEGREE
MD
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12-20-84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
E.T. CARRENO, MD. | | | | 22e. ADDRESS
6101 New Hampshire Ave NE Wash. DC 20011 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
12-27-84 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood, Md. | |
| 24. FUNERAL DIRECTOR
NAME
JOHN T. RHINES Co | | | | ADDRESS
3030-12 St. N.E. | | 25a. DATE REC'D. BY REGISTRAR
IAN 4 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

BP





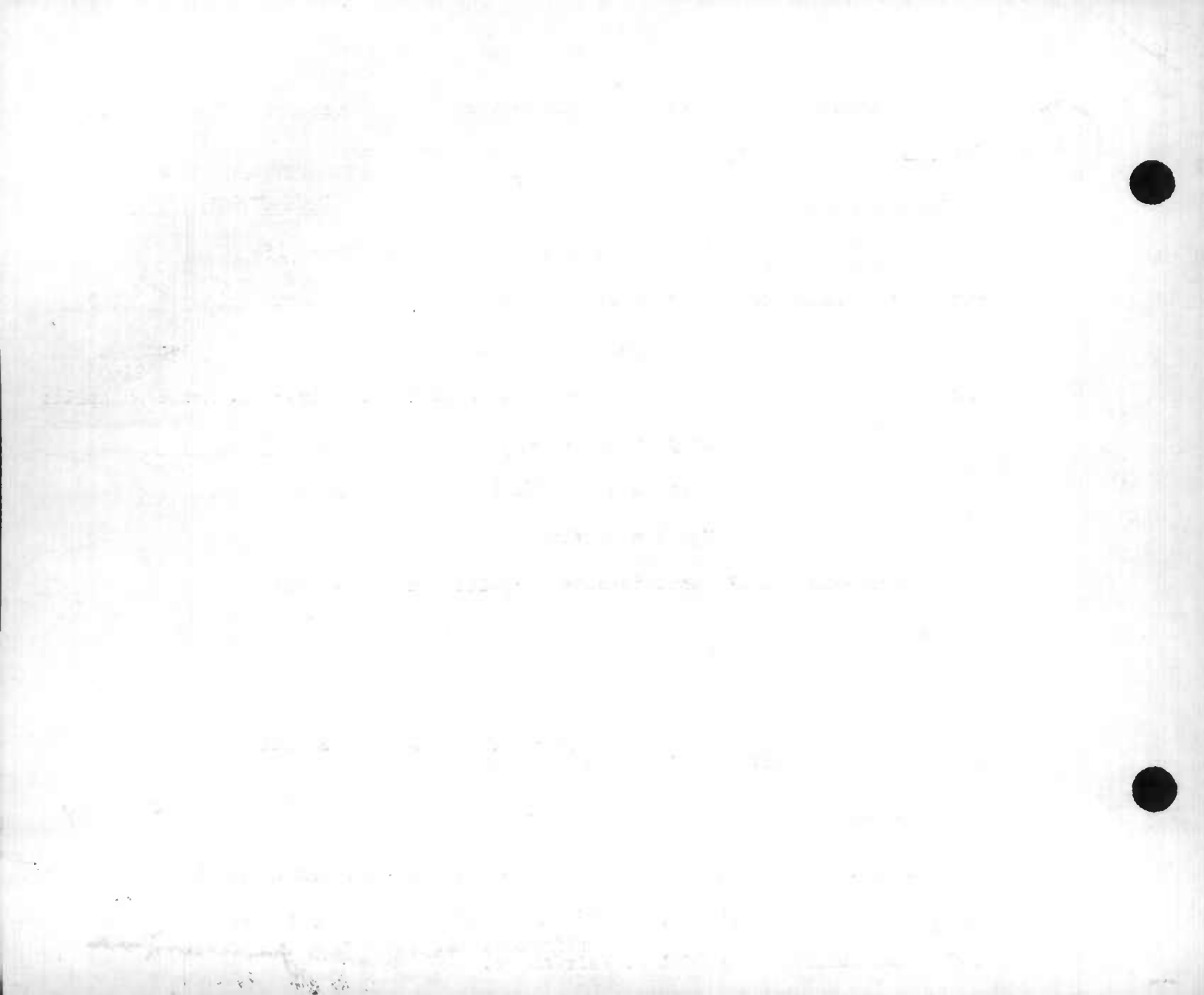
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept until 72 hours after death. If with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to be present.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 34129
REG. NO. | |
|--|--|--|--|---|--|---|---|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
Bertha Louise Quackenbush | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 8 1984 | | | 2b. HOUR
0520 M | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
February 12 08 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda, MD | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Naval Hospital Bethesda, MD | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Virginia | | | 13b. COUNTY
Arlington | | 13c. CITY OR TOWN
Arlington | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2412 North Quincy 22207 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Lang | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mamie Nason | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | 16b. SOCIAL SECURITY NO.
225 64 6854 | | 17. INFORMANT
ADDRESS
Ray Jarrell #3 Milrob Ct. Apt 2 Annapolis 21403 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Left Pleural Effusion</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(c) <u>Massive Ascites</u>
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
<u>Cirrhosis, Renal Insufficiency, Hepatic Encephalopathy</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION
None | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>NOVEMBER 28</u> , 19 <u>84</u> , to <u>DECEMBER 8</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>DECEMBER 8</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Richard L Nemec</i> | | | | DEGREE
MD | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
8 DEC 84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Richard L Nemec, LT, MC, USNR | | | | 22e. ADDRESS
Naval Hospital Bethesda, MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
Dec. 12, 84 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington, VA | | | |
| 24. FUNERAL DIRECTOR
NAME
Arlington Funeral Home 3901 N. Fairfax Dr. | | | | | | | | | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 34130

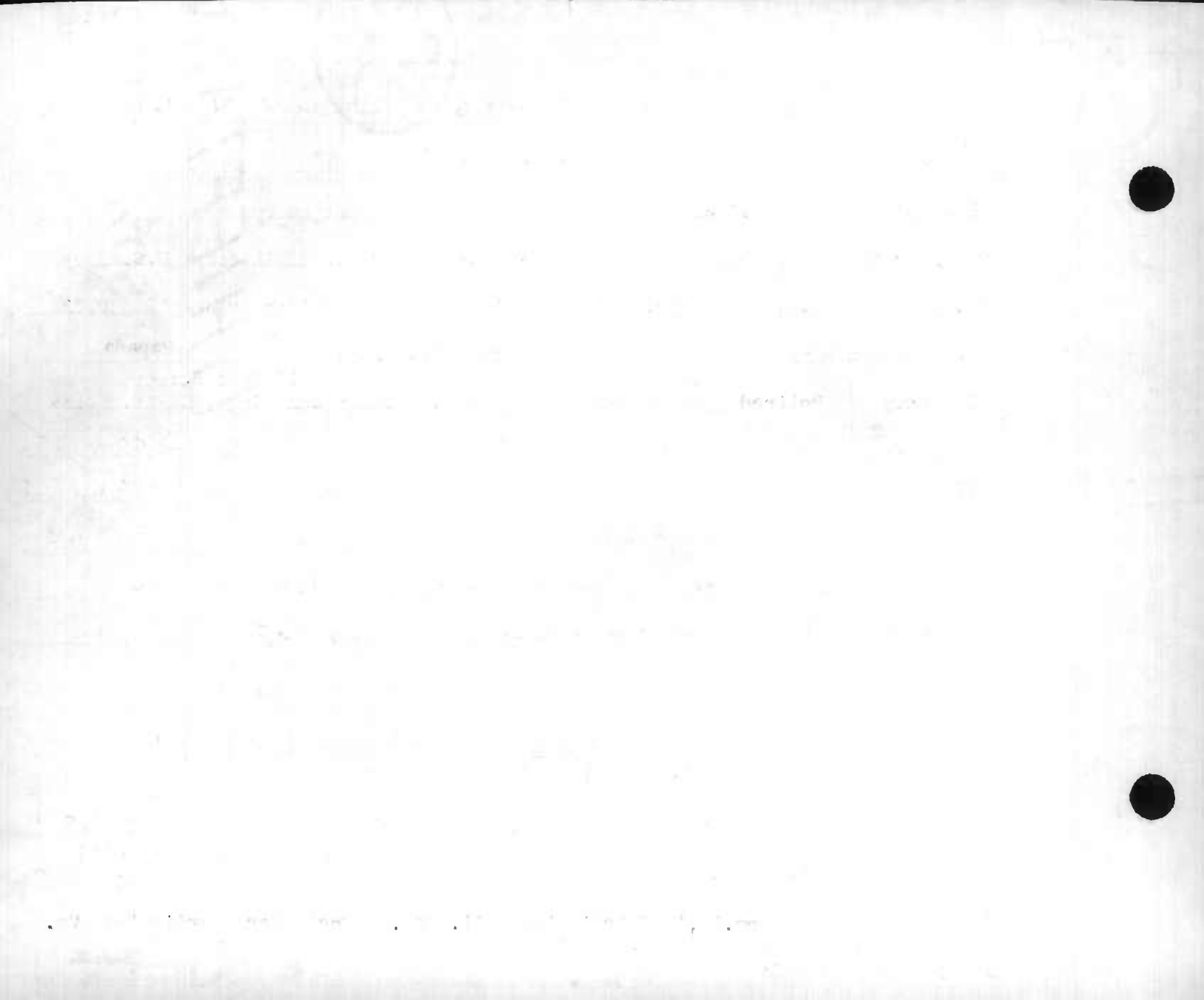
FOR
STATE
REGISTRAR

| | | | | | |
|---|--|--|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
ALEXANDER RAPADA QUIMING | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 7, 1984 | | 2b. HOUR
12:17am | |
| 3. SEX
Male | | 4. RACE
Oriental | | 5. DATE OF BIRTH
MONTH DAY YEAR
January 27, 1921 | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Philippines | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS. | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired Military | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Navy | | | |
| 13a. STATE
Md. | | 13b. CITY OR TOWN
Hyattsville | | 13c. STREET ADDRESS / ZIP CODE
7953 15th Avenue #3 20783 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Anastacio Quiming | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bernabela Rapada | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes Navy | | 16b. SOCIAL SECURITY NO.
Retired 576 38 0016 | | 17. INFORMANT
ADDRESS
7266 Zest Street
Juana C. Quiming San Diego, Calif. 92139 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>cardiac arrest</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Myocardial infarction</u>
(c) <u>Ruptured Abdominal Aortic Aneurysm</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
40 minutes
2-3 minutes
8-10 hrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a
<u>Severe Arteriosclerotic Cardiovascular Disease</u> | | | | | |
| 19a. DATE OF OPERATION
Dec 6, 84 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Ruptured Abdominal Aortic Aneurysm | | 20a. AUTOPSY?
NO | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NO: WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 6, 1984</u> to <u>Dec 7, 1984</u> , that (I) (we) last saw the deceased alive on <u>Dec 6, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
MARQUEZ | | DEGREE
MD | | 22c. DATE SIGNED
Dec 7, 84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JAIME F. MARQUEZ | | 22e. ADDRESS
831 University Blvd (E) Silver Spring Md 20903 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec. 12, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington Natl. Cem. | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Fort Myer Arlington Va. | | 23e. DATE REC'D. BY REGISTRAR
DEC 14 1984 | | 23f. REGISTRAR'S SIGNATURE
Davidson-Randall | |
| 24. FUNERAL DIRECTOR'S NAME
Francis Casch's Sons 4739 Baltimore Avenue Hyattsville, Md 20781 | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 34131

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|--|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
GAIL C. RABER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 13 84 | | 2b. HOUR
2:55 PM |
| 3. SEX
FEMALE | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
November 4, 1911 | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Illinois | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD | | |
| 10. CITY OR TOWN OF DEATH
TAKOMA PARK | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
WASHINGTON ADVENTIST HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Home |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Silver Spring | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Clark Walker Cummings | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bess - Durbin | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
None | | 17. INFORMANT
ADDRESS
John E. Raber (Husband) Same as # 13. | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) MULTIPLE STROKES
DUE TO, OR AS A CONSEQUENCE OF
(b) SUBDURAL HEMATOMA BILATERAL
DUE TO, OR AS A CONSEQUENCE OF
(c) | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
|--|--|---|

| | | | |
|---|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a
ATRIAL FIBRILLATION | | | |
|---|--|--|--|

| | | | |
|---|--|--|---|
| 19a. DATE OF OPERATION
12-7-84 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
SUBDURAL HEMATOMAS | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-5, 1984, to 12-13, 1984, that (we) lost
saw the deceased alive on 12-3, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (If we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Pamela Mulshine MD | | 22c. DATE SIGNED
12-14-84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PAMELA MULSHINE | | 22e. ADDRESS
10500 SUMMIT KENSINGTON MD | |

| | | | |
|---|------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | 23b. DATE
Dec/14/84 | 23c. NAME OF CEMETERY OR CREMATORY
Chambers Crematory | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Riverdale, P.G. Co., Maryland |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Chambers Funeral Home Silver Spring, Maryland | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 4 1 3 2
REG. NO.

1. FOR
STATE
REGISTRAR

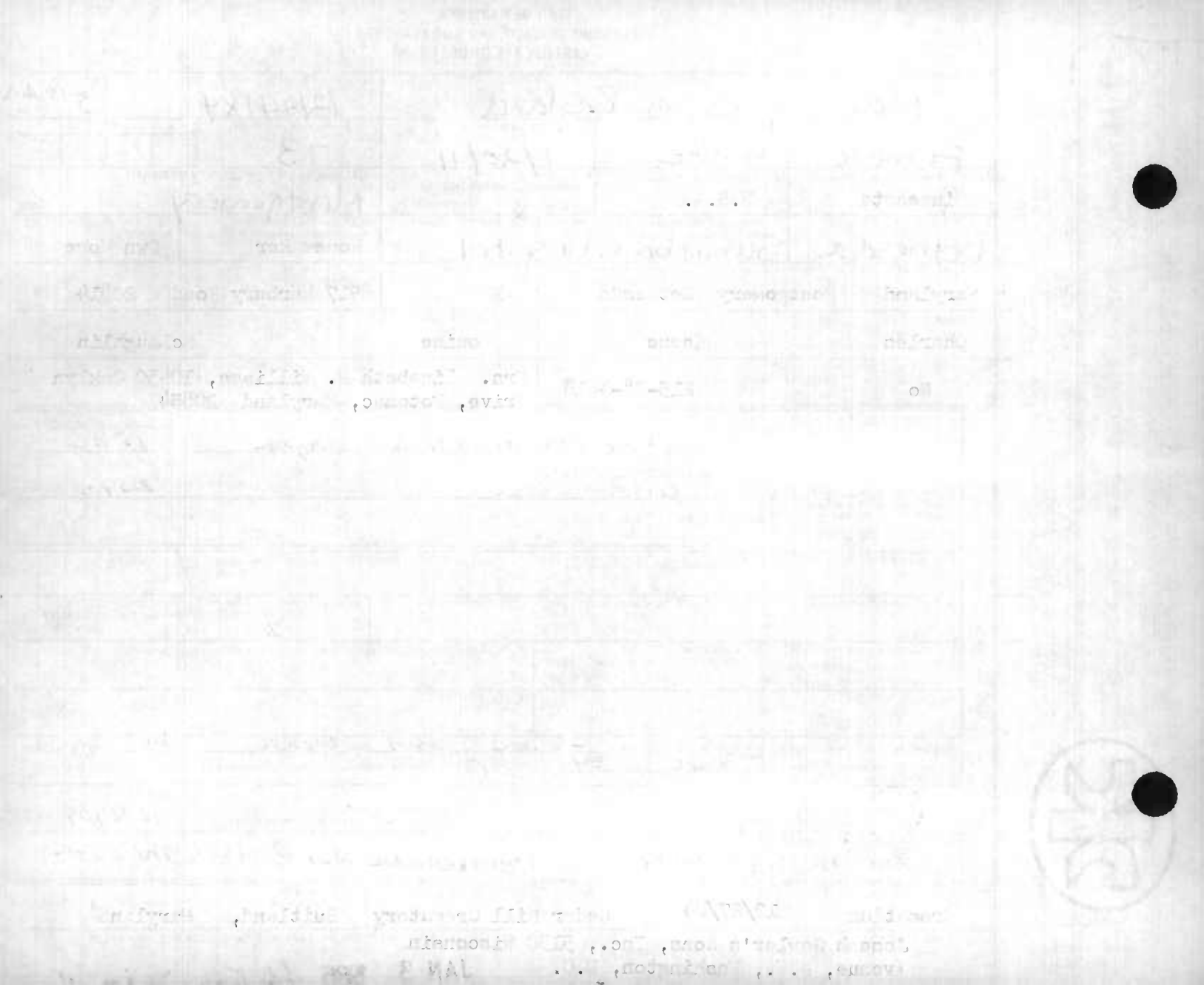
| | | | | | | | | | | |
|--|--|--|---|---|-------------------------------|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Marjory Keene Ragland | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/24/84 | | | 2b. HOUR
5:10 AM | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
1/26/11 | | 6. AGE
(IN YEARS LAST BIRTHDAY)
73 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Minnesota | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
6917 Marbury Road 20814 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Keene | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Louise McLaughlin | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | 16b. SOCIAL SECURITY NO.
215-38-4818 | | 17. INFORMANT
ADDRESS
Mrs. Elizabeth R. Williams, 10430 Oaklyn Drive, Potomac, Maryland 20854 | | | | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>rupture thoracic aortic aneurysm</u>
DUE TO, OR AS A CONSEQUENCE OF,
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
15 hrs
20 yrs |
|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>23 Dec</u> , 19 <u>84</u> , to <u>24 Dec</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>23 Dec</u> , 19 <u>84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>John M. Wymann</u> | | | | DEGREE | | 22c. DATE SIGNED
12/24/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John M. Wymann | | | | 22e. ADDRESS
7201 NORTON AVE Bethesda, Md 20814 | | | |

| | | | | | | | |
|---|--|-----------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
12/27/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland, Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Joseph Gawler's Sons, Inc., 5130 Wisconsin Avenue, N.W., Washington, D.C. | | | | DATE REC'D. BY REGISTRAR
JAN 3 1985 | | 25b. REGISTRAR'S SIGNATURE | |



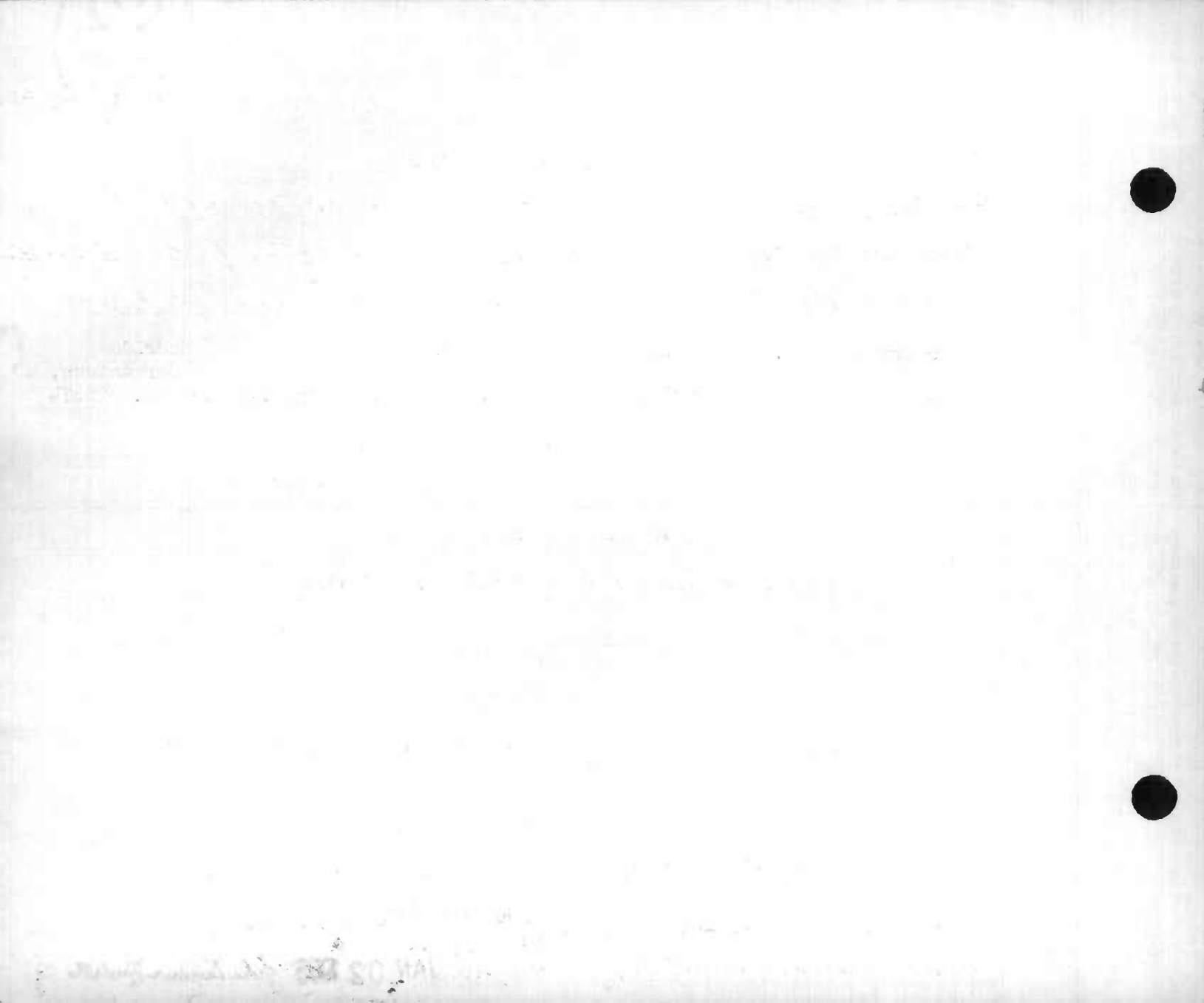
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 3 4 1 3 3
REG. NO. | |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR
STATE
REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
RALSTON RUTH | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12-28-84 | | 2b. HOUR
7:26 AM | |
| 3. SEX
FEMALE | | 4. RACE
CAUC. | | 5. DATE OF BIRTH MONTH DAY YEAR
JULY 14 1923 | | 6. AGE (IN YEARS LAST BIRTHDAY)
61 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
BOSTON, MA. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY Co. MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SYLVAN MANOR MSG Home | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
SECRETARY | | 12b. KIND OF BUSINESS OR INDUSTRY
SELF-EMPLOYED | |
| 13a. STATE
MD. | | 13b. COUNTY
MONT. | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
901 KERWIN ROAD D 20901 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Robert L. Ralston | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Agnes McBride | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> IF YES, GIVE WAR OR DATES
No | | | | 16b. SOCIAL SECURITY NO.
019-12-2319 | | 17. INFORMANT ADDRESS
Katherine Davis 9 Crystal Rock Ct. 20874 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ISCHEMIC HEART DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) DIABETES MELLITUS | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
END STAGE KIDNEY DISEASE, ANEMIA | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NO! WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-9- 19 84 , to 12-28 19 84 , that (I) (we) last saw the deceased alive on 12-21- 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
M. Kahkonen TM | | | | DEGREE
M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12/28/84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. M. KATKINENI | | | | 22e. ADDRESS
3301 NEW MEXICO AVE., N.W. #328, WASH. D.C. 20016 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Removal | | | | 23b. DATE
12-28-84 | | 23c. NAME OF CEMETERY OR CREMATORY
UNIV. MED. SCHOOL | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
WASHINGTON D.C. | | | |
| 24. FUNERAL DIRECTOR NAME
COLUMBIA MORTUARY SERVICES | | | | ADDRESS
225 MISSOURI AVE WASHINGTON, D.C. | | 25a. DATE REC'D. BY REGISTRAR
JAN 02 1985 | | 25b. REGISTRAR'S SIGNATURE
John K. ... | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | |
|--|--|---|--|--|--|---|--|------------------------------|--|-----------------|--|--------------------------------------|--|------|--|----------|--|---|--|
| 1. FOR
STATE
REGISTRAR | | 3 4 1 3 4 | | | | REG. NO. | | | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | | A | |
| Charles | | Franklin | | Rau | | Jr. | | 12 | | 27 | | 84 | | 8:10 | | M | | | |
| 3 SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE | | 7. UNDER 1 YEAR | | 8. UNDER 24 HRS | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Male | | White | | 1 MONTH 4 DAY 29 YEAR | | 55 YRS. | | MONTHS | | DAYS | | HOURS | | MIN. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | |
| Md. | | USA | | | | Montgomery | | MD. | | | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | |
| Gaithersburg | | 6020 Griffith Road | | Manager-Hardware | | Merchandise Hardware | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | | | |
| Md. | | Mont. | | Gaithersburg | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 6020 Griffith Rd. | | 20879 | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | |
| Charles | | F. | | Rau, Sr. | | Nellie | | - | | Smith | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | | | |
| Yes | | WWII | | 218-24-2928 | | Florence G. Rau | | Same as # 13 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bronchogenic carcinoma, left lung</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>3 yrs.</u> | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
<u>Liver metastases, extensive</u> | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | |
| | | | | March 81, 1984, to Dec. 5, 1984 | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 81, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | 22b. SIGNATURE
<u>Donald E. Dillon</u> | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12.27.84 | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DONALD E DILLON, M.D. | | 22e. ADDRESS
2901 Olney- Sandy Spring Rd. Olney, Md. 20832 | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Dec. 29, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Laytonsville | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Laytonsville Mont. Md. | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS H. BARBER | | ADDRESS
LAYTONSVILLE, MD. 20879 | | | | | | | | | | | | | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|---|--------------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST AGNES
LAST MARGUERITE A. Rawson | | | | | 2a. DATE OF DEATH
MONTH 12 DAY 24 YEAR 84 | | 2b. HOUR
5 ⁴⁰ AM | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH 3 DAY 01 YEAR 18 | | 6. AGE (IN YEARS LAST BIRTHDAY)
X65 66 YRS | | 7. UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Wash., D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery City | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Postal Worker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | 13b. COUNTY
Mont. Co | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
511 Spym...
422 Branch Dr. 20901 | |
| 14. FATHER'S NAME
FIRST WILLIAM
MIDDLE C.
LAST SARTAIN | | 15. MOTHER'S MAIDEN NAME
FIRST GERTRUDE
MIDDLE
LAST TRACY | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
577-20-1884 | | 17. INFORMANT
ROBERT J. RAWSON SAME AS 13 HUSBAND | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for parts 1a, 1b, and 1c.)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Adenocarcinoma 2 mos.
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in item 18, part 1 or part 2) | | | | | |
| 21d. INJURY OCCURRED:
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT HOME | | 21e. PLACE OF INJURY
(At home, street, factory, office, farm, etc.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from 12/23/84 to 12/24/84 and that (2) my opinion death occurred on the date and hour and from the causes stated above. (If not, (1) or (2) did not view the body after death.) | | | | | | | | | |
| 22b. SIGNATURE
Alan I. Kermaier, MD | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/24/84 | | | |
| 22d. PHYSICIAN'S NAME
ALAN I. KERMAIER, MD | | 22e. ADDRESS
10313 Georgia Ave. S S Md 20901 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12/28/84 | | 23c. NAME OF CEMETERY OR CREMATORY
ST. JOHN'S CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
FOREST GLEN MONT MD. | | | |
| 24. FUNERAL DIRECTOR
(NAME)
FRANCIS J. COLLINS | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 31 1984 | | 25b. REGISTRAR'S SIGNATURE
Gina Davidson-Randall | | | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | | | | |

1942-1943
From Division 3 of 12
1942-1943
1942-1943
1942-1943

Mexican Abolitionists

X

1942-1943
1942-1943
1942-1943

1942-1943
1942-1943
1942-1943

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy pages 1 and 2 and should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | | | |
|---|---|---|---|
| 1. FOR STATE REGISTRAR | | REG. NO. 34136 | |
| 1. DECEASED NAME (TYPE OR PRINT) Hilda R. Reagle | | 2a. DATE OF DEATH MONTH DAY YEAR 12-7-84 2b. HOUR: 8:00 A.M. | |
| 2. SEX FEMALE | 4. RACE WHITE | 3. DATE OF BIRTH MONTH DAY YEAR NOV. 26, 1896 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 88 | 8. AGE (IN YEARS LAST BIRTHDAY) 88 | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co., MD. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MAINE | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 18. CITY OR TOWN OF DEATH ROCKVILLE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT BLANCH FACILITY, GIVE STREET ADDRESS) NATIONAL LUTHERAN HOME | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK |
| 13a. STATE D.C. | 13b. COUNTY WASHINGTON | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS / ZIP CODE 3001- VEAZEY TERRACE, N.W. |
| 14. FATHER'S NAME JACOB | 15. MOTHER'S MAIDEN NAME MARY ELLEN REICHARD | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | |
| 16b. SOCIAL SECURITY NO. 579-50-9469 | 17. INFORMANT ADDRESS REV. DR. RICHARD REICHARD - NLH - ROCKVILLE, MD | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTE'S MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 1984 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) | |
| 21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from Nov 1 19 84 to Feb 19 84 , that (1) (we) last saw the deceased alive on 2 Dec 19 84 and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (do not) view the body after death. | | | |
| 22b. SIGNATURE Thomas E. Doolley, MD | | 22c. DATE SIGNED 7 Dec 84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS E. DOOLEY, MD | | 22e. ADDRESS 13904 GORDON AVENUE, DUNEY, MD 20830 | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | 23b. DATE DEC. 10, 1984 | 23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY | 23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD, MARYLAND |
| 24. FUNERAL DIRECTOR HYSONG CO., INC- 1300-N STREET, NW WASH., D.C. | | 25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 8 7 1984 | |

1937-12-24 22:00

NOV. 26, 1935
U.S.A.
XX

NATIONAL MUTUAL HOME
D.C.
XX

JACOB
REAR
MARY ELLEN

REAR

NOV. 26, 1935
D.C. DR. RICHARD RICHARD - NEW - RICHARD, MD

REAR

XX

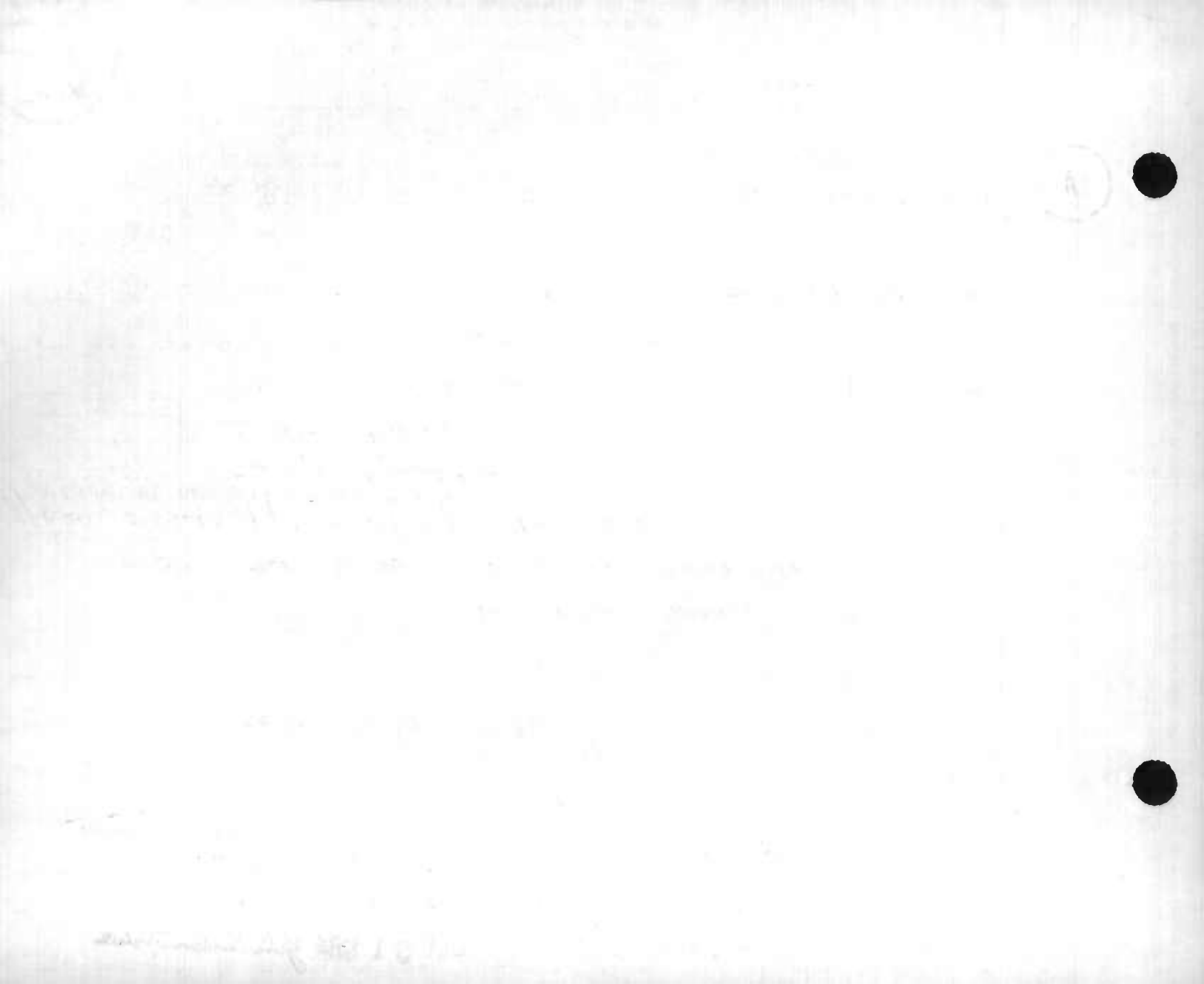
[Handwritten notes and signatures]

REAR
D.C. DR. RICHARD RICHARD - NEW - RICHARD, MD
REAR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| FOR
1- STATE
REGISTRAR | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | REG. NO. 34137 | |
|--|--|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
FRANCES Louise REECE | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 23 1984 | | 2b. HOUR
1-30 PM | |
| 3 SEX
F | 4. RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR
4 4 '10 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS.
IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery Ct. MD. | |
| 10. CITY OR TOWN OF DEATH
TAKOMA PARK | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
nurse | | 12b. KIND OF BUSINESS OR INDUSTRY
private duty |
| 13a. STATE
Maryland | | 13b. COUNTY
Prince George | 13c. CITY OR TOWN
Beltsville | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Jesse Mc Cracken | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Daisy Bradshaw | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
219-14-1227 | | 17. INFORMANT
ADDRESS
Betty Dorsey dame as above | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEVERE CORONARY ARTERY DISEASE</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) <u>PRIMARILY IMPAIRED PULMONARY FUNCTION, RENAL INSUFFICIENCY, COAGULOPATHY, GI BLEEDING, S/P EMBOLECTOMY</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<u>PERIPHERAL EMBOLI 20 TO CARDIAC CATHETERIZATION</u> | | | | | |
| 19a. DATE OF OPERATION
12-21-84 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
BILATERAL EMBOLI | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-20-84 to 12-23-84, that (I) (we) last saw the deceased alive on 12-23-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
I. H. CHANDARY | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
I. H. CHANDARY | | 22e. ADDRESS
10798 HICKORY RIDGE ROAD COLUMBIA MARYLAND 21044 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
Dec. 26, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Westview Memorial Park | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Catonsville, MD | | 24. FUNERAL DIRECTOR
Donaldson Funeral Home, Laurel, Md | | | |
| 25a. DATE REC'D. BY REGISTRAR
DEC 31 1984 | | 25b. REGISTRAR'S SIGNATURE
John Davidson | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the finding of the death.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 34138 | |
|---|--|---|--|--|---|--|---|---|------------------------|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Annie M. Reed | | | | | 2a. DATE OF DEATH MONTH December DAY 13 YEAR 1984 | | | | 2b. HOUR 604 PM | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH 8 DAY 16 YEAR 98 | | 6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | | | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 628 Ritchie Avenue 20910 | | | |
| 14. FATHER'S NAME FIRST Leonard MIDDLE Clarence LAST Allnutt | | | | | 15. MOTHER'S MAIDEN NAME FIRST Catherine MIDDLE Victoria LAST Wilson | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | | 16b. SOCIAL SECURITY NO. 220-26-6859 | | 17. INFORMANT (Daughter) Helen G. Basonic, Silver Spring, Maryland | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarct | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-13-84 to 12-13-84 , that (I) (lost) saw the deceased 12-13-84 , and that in (my) (opinion) death occurred on the date and hour and from the causes stated. | | | | | | | | | | | |
| 22b. SIGNATURE George P. Sengstack, MD | | | | DEGREE MD | | | | 22c. DATE SIGNED 12-13-84 | | | |
| 22d. ADDRESS 9241 Columbia Blvd. Silver Spring, Maryland 20910 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE December 17, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY Monocacy Cemetery | | 23d. LOCATION Bealsville | | COUNTY Maryland | |
| 24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P.A. 300 W. Montgomery Ave., Rockville, MD | | | | | | 25a. DATE REC'D. BY REGISTRAR DEC 18 1984 | | 25b. REGISTRAR'S SIGNATURE L. H. Anderson-Randall | | | |

BP

1. The first part of the document is a list of names and addresses. The names are: John Doe, Jane Smith, and Bob Johnson. The addresses are: 123 Main St, 456 Elm St, and 789 Oak St.

2. The second part of the document is a list of items and their quantities. The items are: Apples, Bananas, and Oranges. The quantities are: 10, 5, and 3.

3. The third part of the document is a list of dates and times. The dates are: 1/1/2020, 2/1/2020, and 3/1/2020. The times are: 10:00 AM, 2:00 PM, and 5:00 PM.

4. The fourth part of the document is a list of locations and their distances. The locations are: New York, Los Angeles, and Chicago. The distances are: 100 miles, 200 miles, and 300 miles.

5. The fifth part of the document is a list of names and their ages. The names are: Alice, Bob, and Charlie. The ages are: 25, 30, and 35.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed and 3 and 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

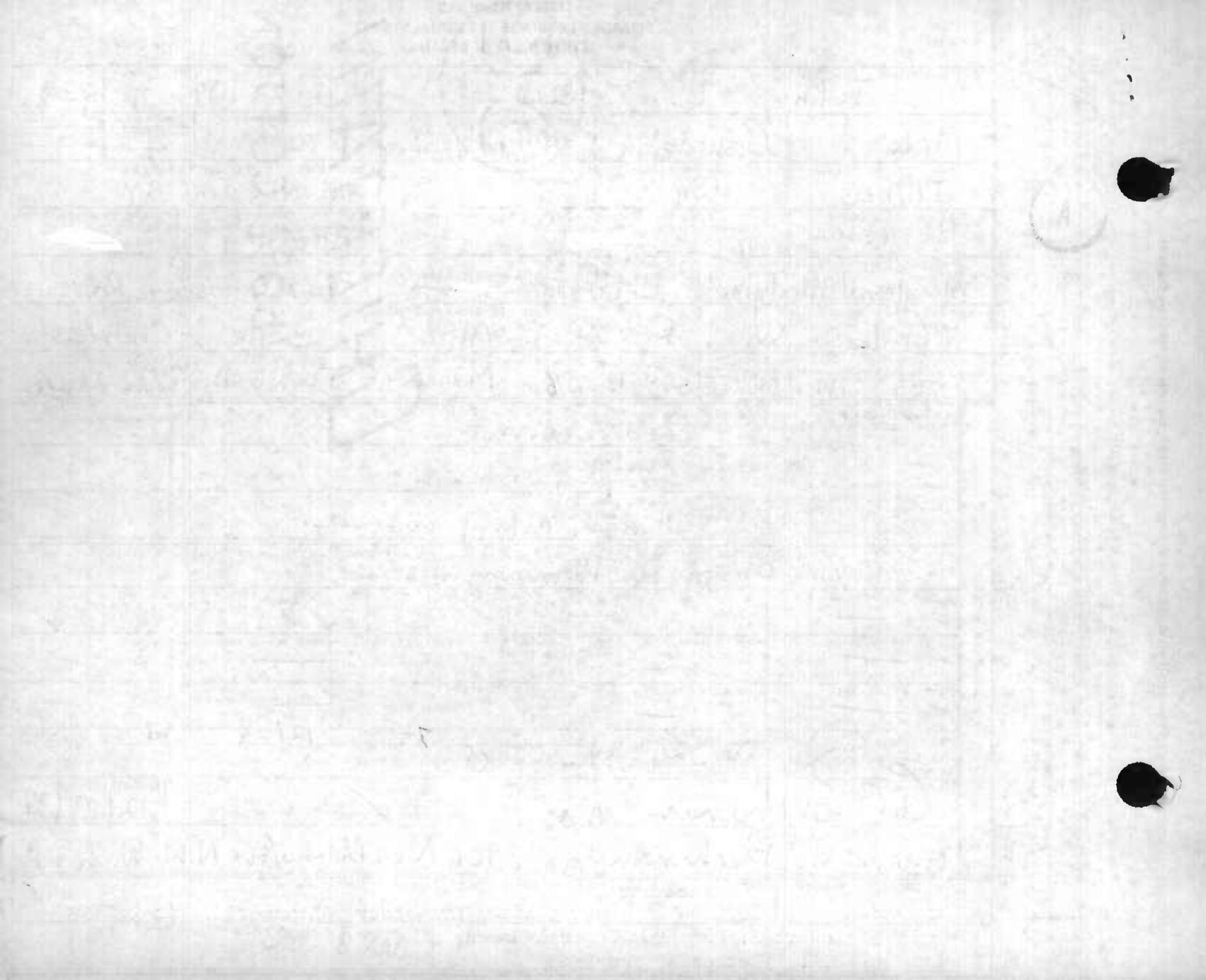
DHMH - 16 50M 7/77
(VRA 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

34139
REG. NO.

FOR
1. STATE
REGISTRAR

| | | | | | | | | | |
|--|--|---|--|---|--------------------------------------|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) John C. REID | | | 2a. DATE OF DEATH MONTH DAY YEAR
12/28/84 | | | 2b. HOUR
948 A M | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
5/10/14 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Illinois | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5407 Goldsboro Road | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Attorney | | 12b. KIND OF BUSINESS OR INDUSTRY
Law | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Charles W. REID | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Alice Belle Charles | | | 13e. STREET ADDRESS
5407 Goldsboro Rd / 20817 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
578-18-7278 | | 17. INFORMANT
Margaret T. REID (wife) | | ADDRESS
(same address) | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Coronary Occlusion
DUE TO, OR AS A CONSEQUENCE OF
(c) Coronary artery disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Chronic Obstructive Pulmonary Disease | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) this hospital attended the deceased on Dec 28, 1984 to 12/28, 1984 , that (2) (we) lost (3) (we) (did) (did not) view the body after death, and that in my (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | | | |
| 22b. SIGNATURE
George C. Buchanan MD | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/28/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
George C. Buchanan MD | | | | 22e. ADDRESS
3301 New Mexico Ave. N.W. Wash, D.C. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
December 29, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria, Virginia | | | |
| 24. FUNERAL DIRECTOR NAME
Robert A. Pumphrey | | | | 24b. FUNERAL HOMES
Bethesda, Maryland | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
JAN 2 1985 | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 34140 | |
|--|--|---|---------------------------|---|------------------------------------|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
EDWARD NMI REINMUTH | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12 30 84 | | | 2b. HOUR
10:25 AM | | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR
SEPT 21, 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS
83 | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASHINGTON, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
CHEVY CHASE RETIREMENT HOME | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
BENEFITS DIRECTOR | | 12b. KIND OF BUSINESS OR INDUSTRY
VA | | | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
10314 RIDGEMOOR DRIVE 20901 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
EDWARD REINMUTH | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
LUCY BRICKER | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
216-44-3156 | | 17. INFORMANT
BARBARA R. HOLLOMAN | | ADDRESS
1509 ELSON STREET
TAKOMA PARK, MD. 20912 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>STROKE</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7 DAYS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>ASPIRATION PNEUMONIA; CHRONIC OBSTRUCTIVE LUNG DISEASE</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>MAY 14, 1984</u> to <u>DECEMBER 30, 1984</u> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <u>12-30, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>David G. Luthringer</u> | | | | DEGREE
M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12-31-84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DAVID G. LUTHRINGER | | | | 22e. ADDRESS
5530 WISCONSIN AVE.
CHEVY CHASE MD. 20915 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
1/3/85 | | 23c. NAME OF CEMETERY OR CREMATORY
FT. LINCOLN | | 23d. LOCATION CITY OR TOWN COUNTY STATE
BRENTWOOD PRT GEO MD. | | | | | |
| 24. FUNERAL DIRECTOR NAME
FRANCIS J. COLLINS | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 4 1985 | | 25b. REGISTRAR'S SIGNATURE
<u>John Davidson-Rendell</u> | | | | | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | | | | | | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

34141
REG. NO.

| | | | | | | | | |
|--|-------------------------------------|--|--|---|---|---|---|-----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
Charlotte L. Reznick | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/1/84 | | | 2b. HOUR
4:43 A.M. | | |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
5 15 06 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE
(CITY OR FOREIGN)
New York | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery City, MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring, Md. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Daly Cross Hospital | | | 12a. USUAL OCCUPATION
(STATE WHETHER OR MANUALLY WORKING)
Retired Teacher | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Md. | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Silver Spg | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
15361 Wallbrook Ct, 20916 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Isadore Littman | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ernestine Weisman | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
577-50-9572 | | 17. INFORMANT
Silver Spring, Md,
Paul Reznick; 15301 Wallbrook Court | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiorespiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost

(b) Massive Aspiration and Gastrointestinal Hemorrhage

DUE TO, OR AS A CONSEQUENCE OF

(c) Cerebrovascular Accident

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct-12, 1984, to Dec 1, 1984, that (I) (we) lost
saw the deceased alive on Nov-30, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Phillip N. Roth, M.D. | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12-1-1984 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Phillip N. Roth, M.D. | | 22e. ADDRESS
818 - 18th Street NW, Wash., DC | | | | | |

| | | | |
|---|------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
12-2-1984 | 23c. NAME OF CEMETERY OR CREMATORY
King David Mem. Gdn. Falls Church, Va. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville, Md. |
| 24. FUNERAL DIRECTOR
NAME
Danzansky-Goldberg Chapels; 1170 Rockville Pike | | | |
| 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
J. Davidson | |



2008

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 34142

FOR
1- STATE
REGISTRAR

| | | | | | | | |
|--|--|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Annie M Richardson | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 8 84 | | | 2b. HOUR
M
7 AM | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 24 99 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
GA. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Home maker | | 12b. KIND OF BUSINESS OR INDUSTRY
own home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS?
Maryland N P. G., Hyattsville YES X NO | | | | 13e. STREET ADDRESS / ZIP CODE
5304 41st Place, 20781 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William J. Landrum | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ellen J. Morris | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
247-38-6038 | | 17. INFORMANT
ADDRESS
Mavis S. Price-Same as items #13 | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | | |
|---|--|---|--|
| IMMEDIATE CAUSE (a) Uremia | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 months | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Renal Calculi | | Years | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Extracerebral | | Days | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **None**

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 12 84 to 19 12 84 , that (I) (we) lost saw the deceased alive on 19 12 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Michael Leibovich, MD | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/8/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Michael Leibovich, MD | | | | 22e. ADDRESS
11120 New Hampshire Ave SS, Md 20914 | | | |

| | | | | | | | |
|--|--|---------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Entombment | | 23b. DATE
Dec. 12, 84 | | 23c. NAME OF CEMETERY OR CREMATORY
Forest Lawn | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Anderson, Anderson Co., S.C. | |
| 24. FUNERAL DIRECTOR
Takoma Funeral Home-Washington, D. C. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 13 1984 | | | |



[The page contains extremely faint, illegible text and markings, possibly bleed-through from the reverse side. Some faint characters are visible at the bottom, including "D.C." and "1941".]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 34143

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|--|--|---|----------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Clifford Homer Richmond</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>12. 4. 84</i> | | 2b. HOUR
<i>1245 AM</i> | | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>Caucasian</i> | | 5. DATE OF BIRTH MONTH DAY YEAR
<i>Sept. 19, 1900</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>84</i> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>New Jersey</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>United States</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery County, MD.</i> | |
| 10. CITY OR TOWN OF DEATH
<i>Gaithersburg</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Herman Wilson Health Care Center</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Minister</i> | |
| | | | | | | 12b. KIND OF BUSINESS OR
<i>Methodist Church</i> | |

| | | | | | | | | | | | |
|---|--|--|---|--|--|------------------------------|---|--|---|--|--|
| 13a. STATE
<i>Maryland</i> | | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Gaithersburg</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<i>401 Russell Ave. 20877</i> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<i>William Richmond</i> | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<i>Hannah C. Harris</i> | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
<i>No</i> | | | 16b. SOCIAL SECURITY NO.
<i>213 38 2593</i> | | | 17. INFORMANT
<i>Wife</i> | | | ADDRESS
<i>same as 13e</i> | | |

| | | | |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause pending for (a), (b), and (c).
PART I: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Acute Respiratory, failure</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause, (a), stating the underlying cause last. (b) <i>Pulmonary Fibrosis</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic obstructive pulm Di's</i> | | 19. ALTERNATE CAUSE OF DEATH (b) <i>Chronic</i>
(c) <i>11</i> | |
|--|--|--|--|

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NESTY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>12/3/84</i> to <i>12/4/84</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If deceased not view the body after death) | | | | | | | |
| 22b. SIGNATURE
<i>Thos G. Ward</i> | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>12/4/84</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Thos G. Ward</i> | | 22e. ADDRESS
<i>6116 Robinson Rd, Bethesda, MD</i> | | | | | |

| | | | | | | | |
|---|--|----------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE OR PRINT)
<i>Burial</i> | | 23b. DATE
<i>Dec. 7, 1984</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Parklawn Memorial Park</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Rockville Maryland</i> | |
|---|--|----------------------------------|--|---|--|---|--|

| | | | | | |
|---|--|--|--|---|--|
| 24. FUNERAL DIRECTOR
NAME
<i>Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland 20814</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>DEC 6 1984</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson Handell</i> | |
|---|--|--|--|---|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examination must be notified above.

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 4 1 4 4

| | | | | | | | | | | | |
|--|--|--|--|---|---|--|---|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) GLADYS ETTA RICHMOND | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-27-1984 | | | 2b. HOUR
1:30 P | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
9-28-16 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 | | 7. UNDER 1 YEAR
MONTHS DAYS
YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
W. VA. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hosp. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife-Dietary Aide | | 12b. KIND OF BUSINESS OR INDUSTRY
Hosp. | | | |
| 13a. STATE
md | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1564 East - West Highway 20910 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
EMIT EWING | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
GRACE BIGGS | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO.
236-52-1676A | |
| 17. INFORMANT
James R. Richmond, Son, | | | | | | ADDRESS
SS, Md. 20910
1564 Eastwest Hwy., | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 d | | |
| DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Myocardial infarction | | | | | | | | | 2 d | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Hypertension, Diabetes | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (this hospital) attended the deceased from 12/26/84 to 12/27/84 , the (we) last saw the deceased alive and above (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Peter Sherer | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
12/27/84 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Peter Sherer | | | 22e. ADDRESS
MD 3947 Ferrara Dr. Wheaton md | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
Dec. 29, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring, Mont. Cty., Md. | | | |
| 24. FUNERAL DIRECTOR
W.W. CHAMBERS CO., 8655 Ga., Ave., S.S. Md. 20910 | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 31 1984 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson | | | |

BP

20% COTTON

WHITE



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 34145

1 - FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
RUSSELL L. RICKETTS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/13/84 | | | 2b. HOUR
11:10AM | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 11 27 | | 6. AGE (IN YEARS LAST BIRTHDAY)
57 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SHADY GROVE ADVENTIST HOSP | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CONSTRUCTION | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Germantown | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
18503 Nutmeg PL 20874 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Harvey V. Ricketts | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sadie Mobley | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
218-20-0811 | | 17. INFORMANT
Mabel Day Parnassau Md. 20877 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Vascular Failure + Aneurysm</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Hypertension + Cerebral Aneurysm</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Hypertension</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Chronic obstructive pulmonary disease</u> | | | | | | | | | |
| 19a. DATE OF OPERATION
12/11/84 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Hemiparesis | | | | 19c. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/13/84</u> to <u>12/13/84</u> , that (I) (we) lost
saw the deceased alive on <u>12/13/84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
William Daniels | | | | DEGREE
MD
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12/18/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
William Daniels | | | | 22e. ADDRESS
12-13 E Deep Park Dr. Germantown | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/17/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Resthaven Memorial | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Frederick Frederick Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
W.C. Hutton | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 19 1984 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Rodella | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE SECRETARY OF THE INTERIOR
FROM THE LAND MANAGER
SUBJECT: [Illegible]

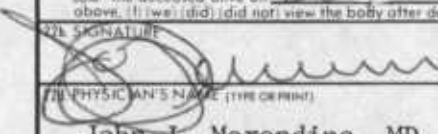
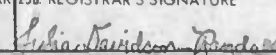
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100. [Illegible]



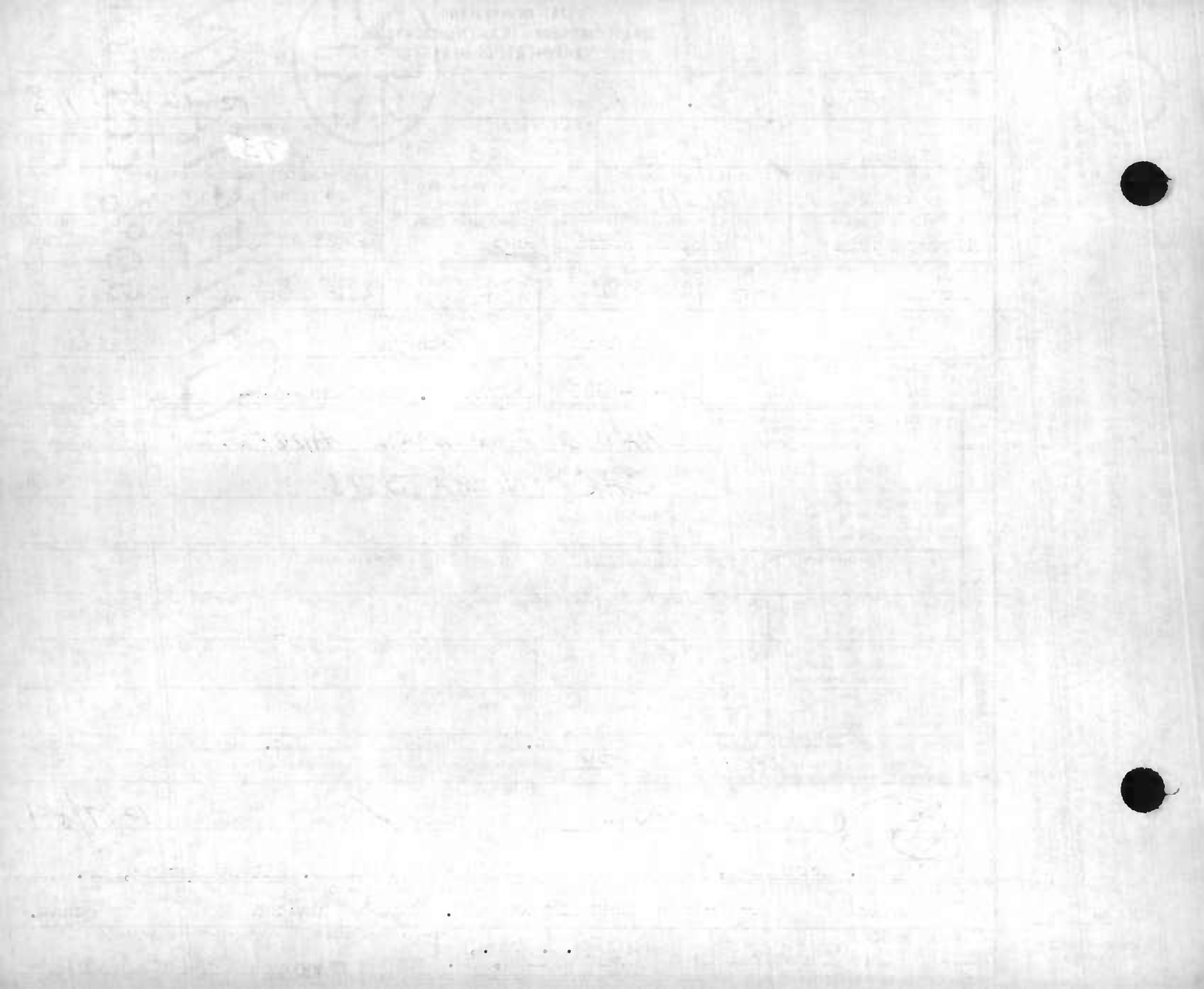
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 34146
REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST
Evelyn | | MIDDLE
M. | | LAST
Ridings | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 16 84 | |
| 3 SEX
Female | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
4 23 09 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | | 2b. HOUR
11 AM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pa. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Fairland Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Budget analysis | | 12b. KIND OF BUSINESS OR INDUSTRY
Retired | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
4815 Oxbow Road, 20852 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Dentith | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Kathryn Williams | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
N/A | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | | 17. INFORMANT ADDRESS
Shirley D. Donaldson-dau-(same as 13e) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>CARCINOMATOSIS</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT HOME | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) XXXXXX attended the deceased from <u>Dec. 1</u> 19 <u>84</u> to <u>Dec. 16</u> 19 <u>84</u> , that (I) was lost
saw the deceased alive on <u>Dec 5</u> 19 <u>84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) was (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
 | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/17/84 | | | |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT)
John J. Merendino, MD | | | | 23b. ADDRESS
11620 Kemp Mill Rd. Silver Spring, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12-19-1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Northampton Mem. Shrine | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Easton Penna. | | | |
| 24. FUNERAL DIRECTOR
NAME
Hines/ Rinaldi Funeral Home | | | | ADDRESS
11800 N.H. Ave.
Silver Spring, Md. | | 25a. DATE REC'D. BY REGISTRAR
DEC 17 1984 | | 25b. REGISTRAR'S SIGNATURE
 | |

BP

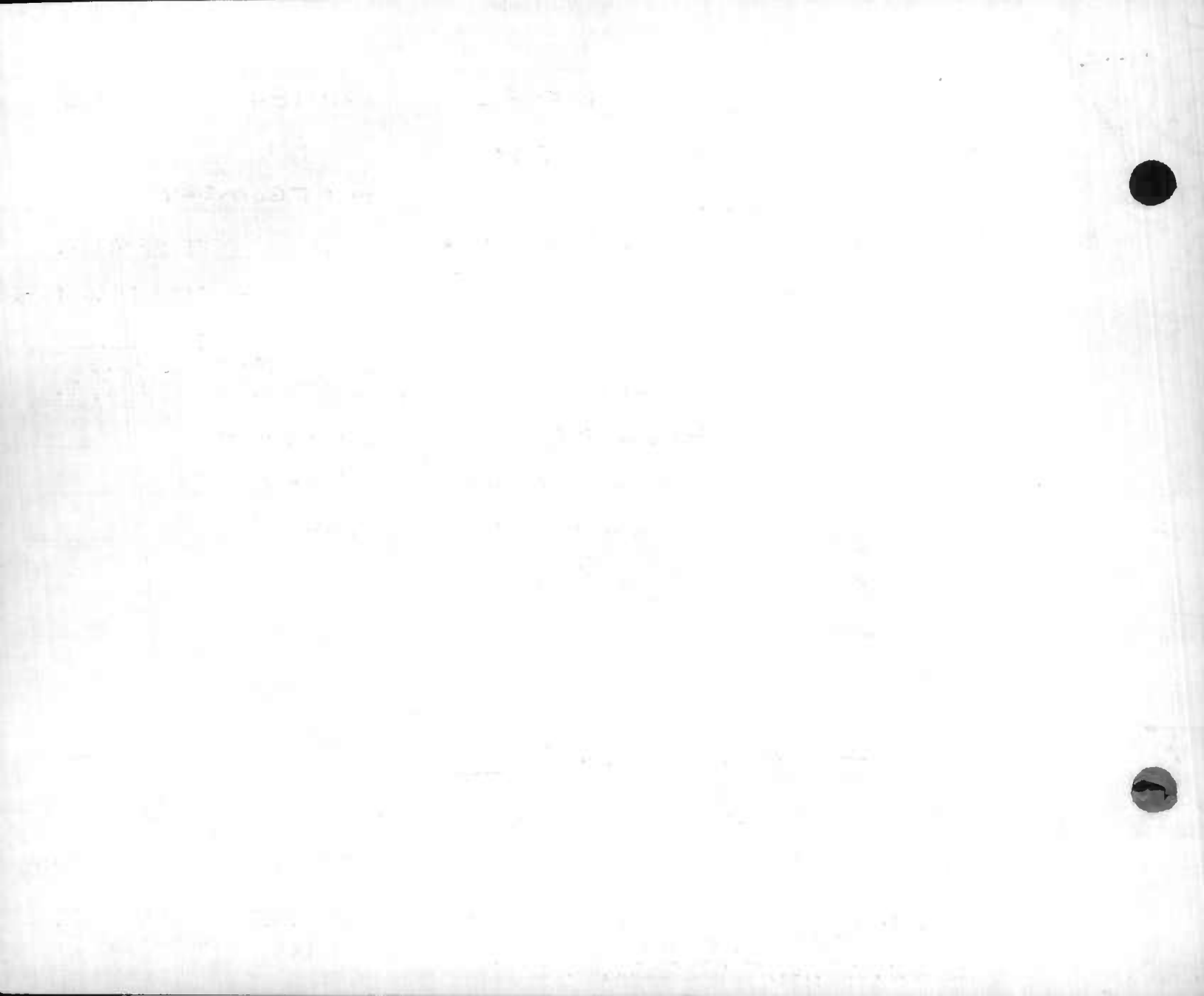


STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 34147

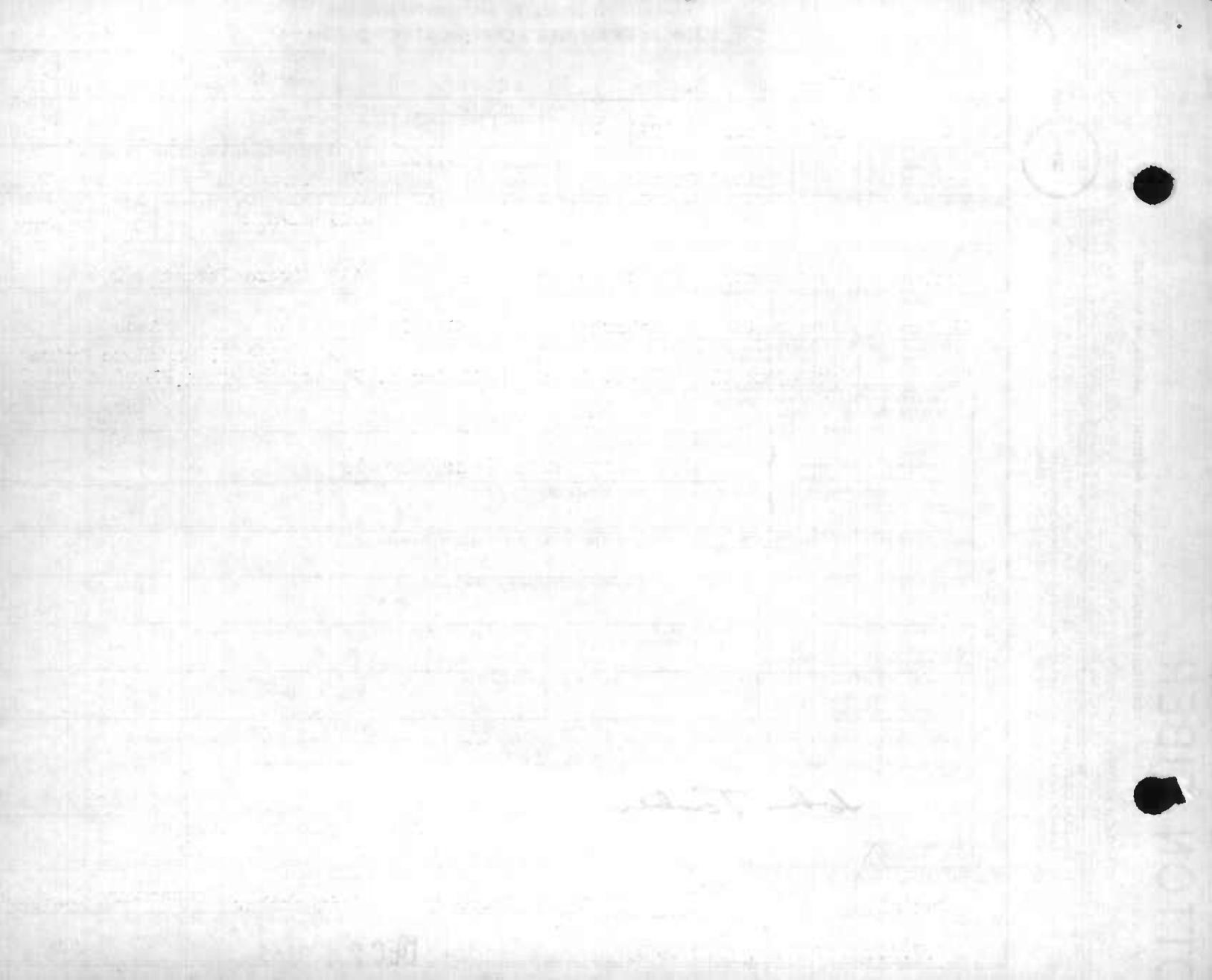
1 - FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|--|---|---|------------------------------------|--|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
ETTA L. RIESER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/11/84 | | | 2b. HOUR
10:55 AM | | | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
SEPT 22, 1884 | | 6. AGE (IN YEARS LAST BIRTHDAY)
100 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SUBURBAN HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CLERK | | 12b. KIND OF BUSINESS OR INDUSTRY
DEPT OF AGRIC. | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
FRANK RIESER | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
PAULINE GILLESHEIMER | | | 13e. STREET ADDRESS / ZIP CODE
8811 COLESVILLE ROAD 20910 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
579-60-0768 | | 17. INFORMANT
NIECE DOROTHY M. McDONOUGH, UPPER MARLBORO, MD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>FLU - Bronchopneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Smoked Chronic Bronchitis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) <u>Conjunctive Heart failure</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
<u>Ischemic Heart Disease</u> | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
11/27/84 |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1979 to 12-11 1984, that (I) (we) last saw the deceased alive on 12-11 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | 22c. DATE SIGNED
12-12 84 |
| 22b. SIGNATURE
Roland J. Imperia MD | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROLAND J IMPERIAL | | 22e. ADDRESS
4977 BATTERY LANE BETHESDA MD 20814 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12/14/84 | | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
SILVER SPRING MONT MD | | | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 17 1984 | | 25b. REGISTRAR'S SIGNATURE
John J. ... | | | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 34148 | | | |
|---|--|-----------------------------|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Dudley L. Robertson | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR
Dec 19 84 | | 2b. HOUR
7a | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
Oct. 14, 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | | IF UNDER 1 YR. MONTHS DAYS
73 | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR
Dec. 20 1984 | | 2d. HOUR
30 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County | | | |
| 10. CITY OR TOWN OF DEATH
Gaithersburg | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
412 Girard Street #204 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Taxi Driver | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Cab Company | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
412 Girard Street #204 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
William Daniel Robertson | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Nannie Amos | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
Yes | | | | 16b. SOCIAL SECURITY NO.
World War II 579-20-1622A | | 17. INFORMANT ADDRESS
Son 6011 N. Bayshore Drive William K. Robertson Miami, Florida 33137 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. Coronary Arteriosclerosis
(b) Coronary Arteriosclerosis
(c) | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE John Tauber | | | | TITLE (SPECIFY) Deputy | | | | DATE SIGNED Dec 20, 1984 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) John Tauber, M.D. | | | | ADDRESS 8218 Wisconsin Avenue Bethesda, Maryland 20814 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Dec. 23, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Gaithersburg Montgomery Maryland | | | |
| 24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY | | | | 24b. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| HOMES, P.A., BETHESDA, MARYLAND | | | | DEC 24 1984 | | | | | | | | | |



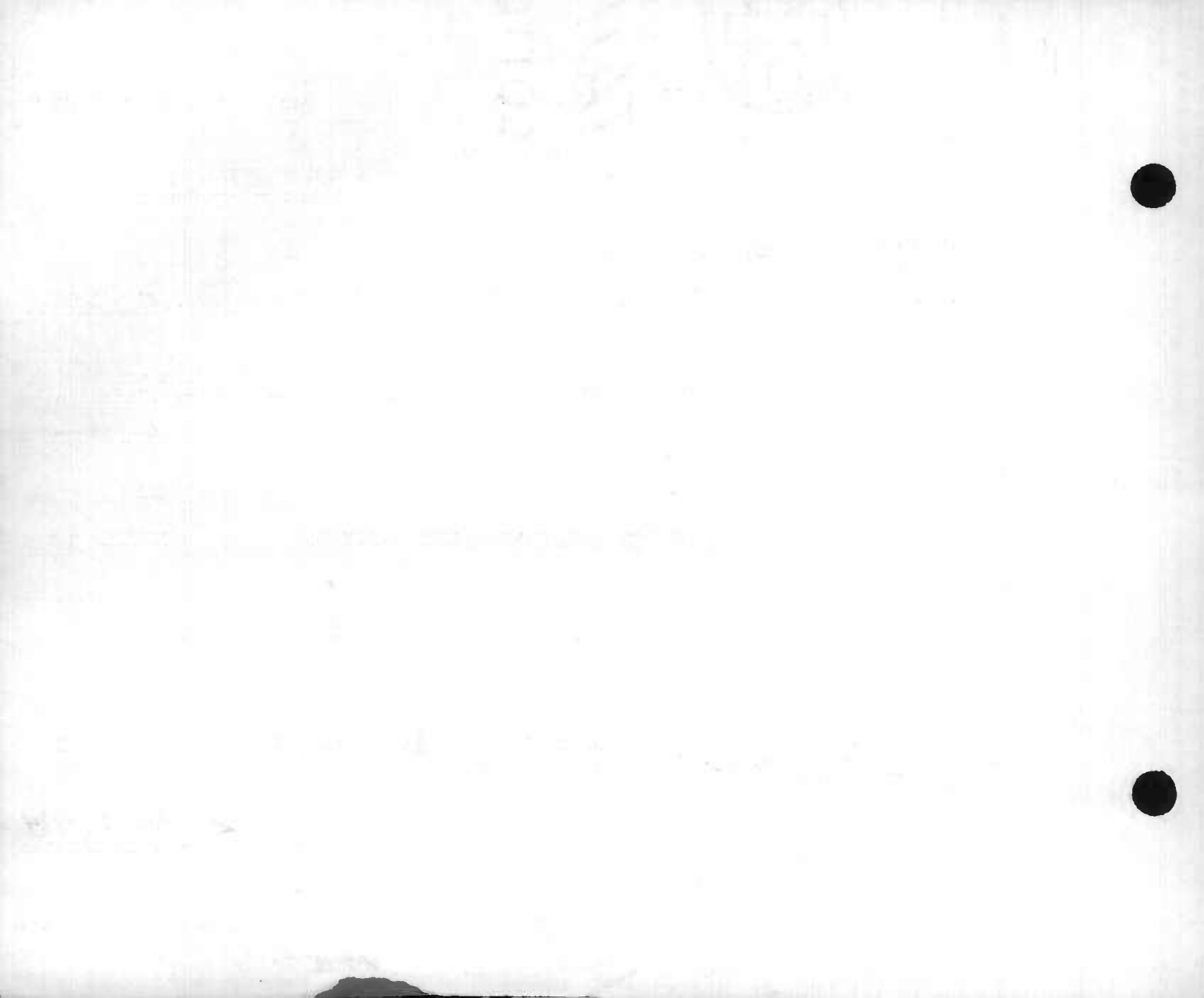
Film G607 item 2b

FOR 9/24/85 rja
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1-45

| | | | | | | | |
|--|--|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) William Russell Robertson | | | 2a. DATE OF DEATH MONTH DAY YEAR
December 1, 1984 | | | 2b. HOUR
1:52 A M | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
March 4, 1944 | | 6. AGE (IN YEARS LAST BIRTHDAY)
40 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NIH, The Clinical Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
D. C. | | 13b. COUNTY | | 13c. CITY OR TOWN
Washington | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
173-36-9512 | |
| 17. INFORMANT
ADDRESS
29 Delaware Ave. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) LOBAR PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) SEPSIS
DUE TO, OR AS A CONSEQUENCE OF
(c) ACQUIRED IMMUNODEFICIENCY SYNDROME | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Hours-Days
DAYS
MONTHS | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | |
| 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 18 , 19 84 , to Dec. 1 , 19 84 , that (I) (we) last saw the deceased alive on December 1 , 19 84 , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) not view the body after death. | | 22b. SIGNATURE
Douglas L. Mallory
22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Douglas L. Mallory | |
| 22c. DATE SIGNED
Dec 1, 1984 | | 22e. ADDRESS
Clinical Center, National Institutes of Health, Bethesda, Md. 20205 | | 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
12/3/84 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Maple Hill | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Wilkes Barre Luzerne Pa | | 24. FUNERAL DIRECTOR
NAME
Ruth S. Howell | | 25a. DATE REC'D. BY REGISTRAR
1984 9 30 | |



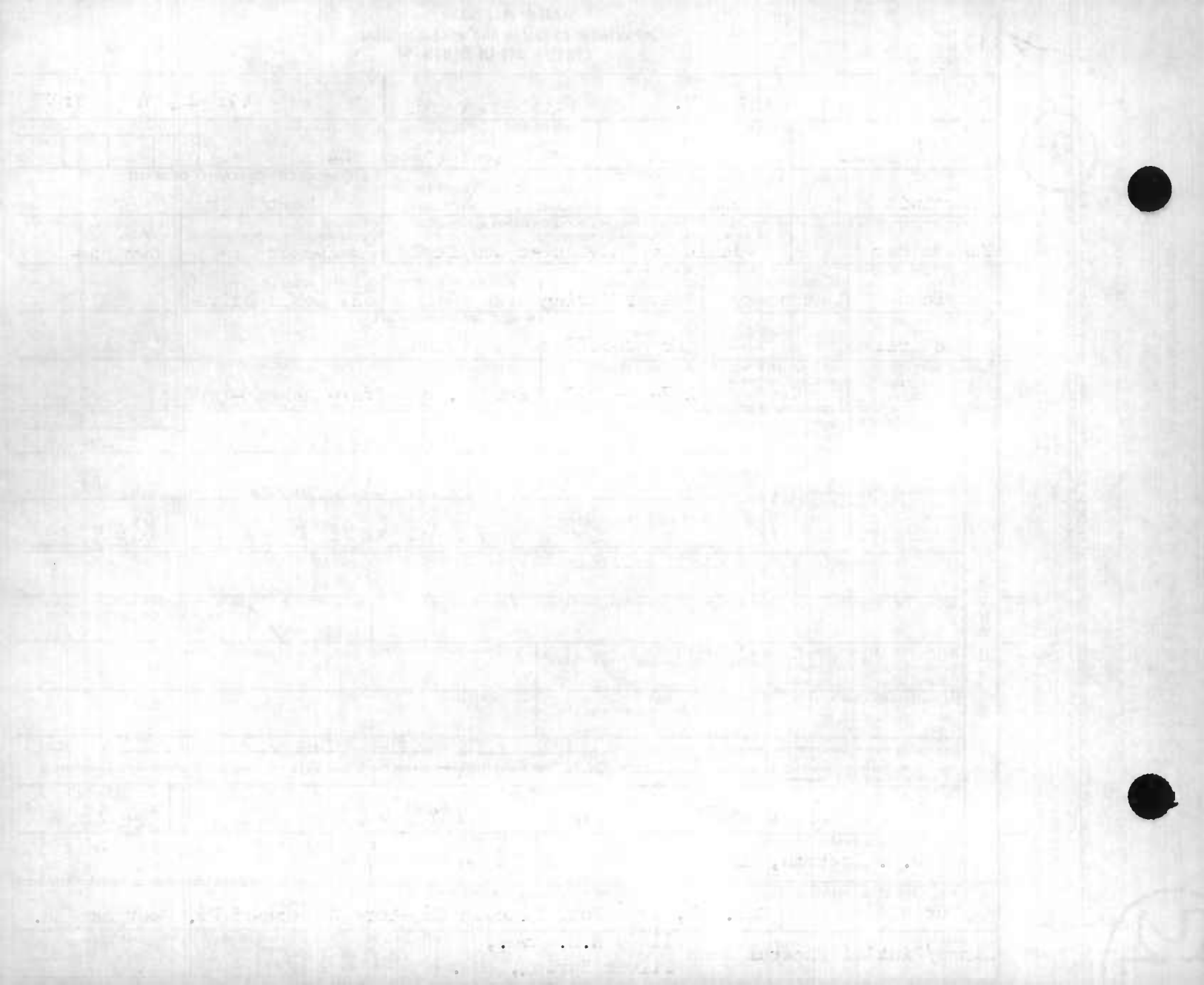
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 34150
REG. NO. | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR 12 23 84 | | | | 2b. HOUR 6:PM M | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ARLENE V. RODEFFER | | | | 3. SEX Female | | | | 4. RACE White | |
| 5. DATE OF BIRTH MONTH DAY YEAR 8 15 1900 | | | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 84 YRS. | | | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | 10. CITY OR TOWN OF DEATH Takoma Park | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | | | 12b. KIND OF BUSINESS OR INDUSTRY own home | | | | | |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Montgomery Silver Spring | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS 621 Hobbs Drive 20904 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles Meyerhoeffer | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Verna Riddel | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A (IF YES, GIVE WAR OR DATES) N/A | | | | 16b. SOCIAL SECURITY NO. 217-34-0855 | | | | 17. INFORMANT ADDRESS Ivan E. Rodeffer-husband-(same as 13e) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Insufficiency
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Carcinoma
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Carcinoma of Left Breast | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 1 yr. 28 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0 | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 14, 1984, to Dec 23, 1984, that (I) (we) lost the deceased alive on Dec 23, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE W.W. Eastman MD. | | | | 22c. DATE SIGNED Dec 23, '84 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) W.W. Eastman, MD | | | | 22e. ADDRESS 831 University Blvd E. Silver Spring Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (5% FEE) Burial | | | | 23b. DATE Dec. 27, 1984 | | | | 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery Brentwood Pr. Georges Md. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | 24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home 11800 N.H. Ave., Silver Spring, Md. | | | | | |
| 25a. DATE REC'D. BY REGISTRAR DEC 24 1984 | | | | 25b. REGISTRAR'S SIGNATURE J. H. Davidson-Randall | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 34151
REG. NO. | |
|---|--|---|--|--|--|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR | | 1 DECEASED NAME (TYPE OR PRINT)
George C. Roeming | | | | 2a DATE OF DEATH MONTH DAY YEAR
December 27, 1984 | | | | 2b. HOUR
1:57A ^M | |
| 3 SEX
Male | | 4 RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
August 29, 1908 | | 6 AGE (IN YEARS LAST BIRTHDAY)
76 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wisconsin | | 7b CITIZEN OF WHAT COUNTRY?
United States | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | | |
| 10 CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Collingswood Nursing Center | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Patent Office | | 12b KIND OF BUSINESS OR INDUSTRY
U.S. Gov't. | | | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS
10 Dale Drive 20850 | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
Ferdinand A. Roeming | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Wanda E. | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | 16b SOCIAL SECURITY NO.
WW II 216 44 3593 | | 17 INFORMANT Brother Robert F. Roeming | | 6078 th N. Oakland Hills Rd. Nashotah, Wisc. 53058 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CANCER OF TONGUE</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 YR</u> | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) <u>(the hospital)</u> attended the deceased from <u>21 Aug 1984</u> to <u>27 DEC 1984</u> , that (1) <u>was</u> lost saw the deceased alive on <u>25 DEC 1984</u> , and that in my <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (1) <u>was</u> and did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Walter E. Goozh, M.D.</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
27 DEC 84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Walter E. Goozh, M.D. | | | | 22e. ADDRESS
2309 Shorefield Road
Wheaton, Maryland 20902 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
Dec 28, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | | 23d. LOCATION CITY OR TOWN
Alexandria | | COUNTY STATE
Virginia | | | |
| 24 FUNERAL DIRECTOR NAME
Robert A. Pumphrey
P.A., Rockville, Maryland | | | | 25a. DATE REC'D BY REGISTRAR
JAN 2 1985 | | 25b. REGISTRAR'S SIGNATURE
<u>Jana Burdett</u> | | | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 about any injury, or other traumatic event, the medical examiner must be notified.

BP

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | Margaret Rosenberger | | | | REG. NO. 34152 | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
MARGARET ROSENBERGER | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12 10 84 | | 2b. HOUR
0148 A M | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
JULY 20, 1887 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
97 | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY CO. MD. | | | |
| 10. CITY OR TOWN OF DEATH
ROCKVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
CASHIER | | 12b. KIND OF BUSINESS OR INDUSTRY
UNKNOWN | |
| 13a. STATE
MD. | | 13b. COUNTY
UNKNOWN | | 13c. CITY OR TOWN
LINEBORO | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
21605 - GUNPOWDER ROAD 21088 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
JOHN C. DUDRON | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
AGNES EAGAN | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | |
| | | 16b. SOCIAL SECURITY NO.
218-26-1371B | | 17. INFORMANT ADDRESS
REV. DR. RICHARD REICHARD - N.L.H. - ROCKVILLE, MD | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) LOBAR PNEUMONIA, RUL HELL
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MONTHS | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY 19 82 to 10 DEC 84 , that (I) was last saw the deceased alive on 10 DEC 84 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Thomas E. Doherty, MD | | DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
10 DEC 84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Thomas E. Doherty, MD | | 22e. ADDRESS
17904 BELKIN AVE
CRNEY, MARYLAND 20832 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
DEC. 13, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
LOUDON PARK CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE
BALTIMORE, MARYLAND | | | |
| 24. FUNERAL DIRECTOR NAME
HYSONG CO., INC - 1300-N ST., NW | | | | ADDRESS
WASH., DC | | 25a. DATE REC'D. BY REGISTRAR
DEC 17 1984 | | 25b. REGISTRAR'S SIGNATURE
Julia Swindon-Rodriguez | |

5

22

x

REF ID: A66549

100

25X

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M
 BP _____
 DHMH - 17
 (VR A15 ME (5))

 1- FOR
 STATE
 REGISTRAR

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

 3 4 1 5 3
 REG. NO.

| | | | | | | | | | | |
|--|---------------------------|---|--|--|---|---|---|--|-------------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Gregory B. Roshan | | | 2a. DATE KNOWN OF DEATH
XX MONTH DAY YEAR
12-16 19 84 | | | 2b. HOUR
M
7:39 | | | | |
| 3. SEX
MALE | 4. RACE
(WHITE) | 5. DATE OF BIRTH
MONTH DAY YEAR
NOV 2, 1984 | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
1 14 | IF UNDER 24 HRS
HOURS MIN
14 | | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
12-16 19 84 | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
N/A | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
ROCKVILLE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
10220 LAKEWOOD DRIVE 20850 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ARIJANG N. ROSHAN | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
WENDY B. HAIMES | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
N/A | | 17. INFORMANT
ARIJANG N. ROSHAN | | | ADDRESS
SAME AS 13 FATHER | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Dennis F. Smyth</i> | | | TITLE (SPECIFY)
Assistant | | | MEDICAL EXAMINER | | DATE SIGNED 12-17-84 | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Dennis F. Smyth, M.D. | | | ADDRESS
111 Penn St., Balto., Md. 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
SILVER SPRING MONT MD. | | | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS | | | | | 25a. DATE REC'D BY REGISTRAR
DEC 19 1984 | | | | | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | <i>Julia Davidson-Hendall</i> | | | | | |

MEDICAL CERTIFICATION

1000

1000



1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

DHMH - 16 50M 4/B3
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | 3 4 1 5 4
REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST <u>Robert</u> MIDDLE <u>E.</u> LAST <u>Rosselot</u> | | | | | | 2a. DATE OF DEATH MONTH <u>12</u> DAY <u>3</u> YEAR <u>84</u> | | 2b. HOUR <u>6:30 PM</u> | |
| 3. SEX
<u>Male</u> | | 4. RACE
<u>White</u> | | 5. DATE OF BIRTH MONTH <u>Dec.</u> DAY <u>14</u> YEAR <u>1922</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>61</u> YRS. | | IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u> IF UNDER 24 HRS. HOURS <u></u> MIN. <u></u> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>New Jersey</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Montgomery</u> MD | | | |
| 10. CITY OR TOWN OF DEATH
<u>Bethesda</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Suburban Hospital</u> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Foreign Serv. off. Dept.</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>State</u> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE <u>Md.</u> | | | | 13b. CITY OR TOWN
<u>Montgomery</u> | | 13c. CITY OR TOWN
<u>Bethesda</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST <u>Eugene</u> MIDDLE <u>R.</u> LAST <u>Rosselot Sr</u> | | | | 15. MOTHER'S MAIDEN NAME FIRST <u>Emily</u> MIDDLE <u></u> LAST <u>Smith</u> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
<u>Yes</u> | | | | 16b. SOCIAL SECURITY NO.
<u>008-14-4811</u> | | 17. INFORMANT ADDRESS
<u>Audrey L. Rosselot. Same as item 13.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) <u>Respiratory Arrest.</u>
DUE TO, OR AS A CONSEQUENCE OF:
(b) <u>Refractory heart failure</u>
DUE TO, OR AS A CONSEQUENCE OF:
(c) <u>Coronary artery disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u></u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<u>P.M.</u> <u></u> <u></u> <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-3</u> , 19 <u>84</u> , to <u>12-3</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>12-3</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Christopher Unger M.D.</u> DEGREE | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>12/3/1984</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Christopher Unger, M.D.</u> | | | | | | 22e. ADDRESS
<u>8218 Wisc. Ave., Bethesda, Md. 20814</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE)
<u>Cremation</u> | | 23b. DATE
<u>12/7/1984</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Cedar Hill Crematory</u> | | 23d. LOCATION
CITY OR TOWN <u>Suitland</u> COUNTY <u>Maryland</u> STATE <u></u> | | | |
| 24. FUNERAL DIRECTOR
NAME <u>Joseph Gawler's Sons Inc.</u> ADDRESS <u>5130 Wisc. Ave., N.W. Wash., D.C.</u> | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
<u>UCL 111 1984 Julie Davidson-Randall</u> | |

BP

Page 10

Page 11

Page 12
X

Page 13

Page 14

Page 15

Page 16

Page 17

Page 18

Page 19

Page 20

Page 21

Page 22

Page 23

Page 24

Page 25

Page 26

Page 27

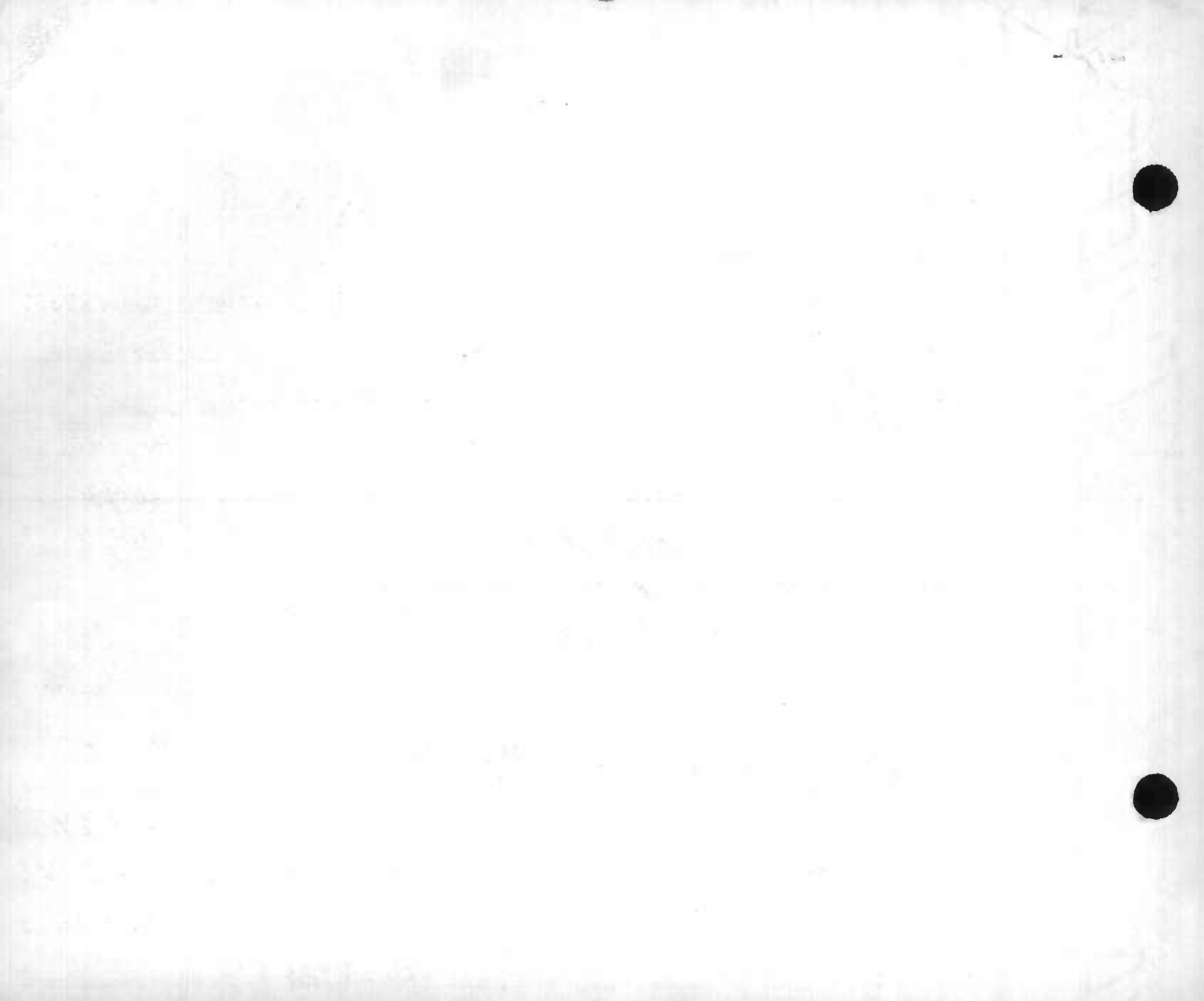
may be **B** page 3
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

 34155
 REG. NO.

| | | | | | |
|--|---|---|--|---|---|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Victor E. Roth | | 12-6-84 | | 1040 P M | |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR
May 27, 1930 | 6. AGE (IN YEARS LAST BIRTHDAY)
54 YRS. | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Nebraska | 7b. CITIZEN OF WHAT COUNTRY?
United States | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Mechanic | 12b. KIND OF BUSINESS OR INDUSTRY
Automobile | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Rockville | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
534 Anderson Avenue/20850 |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Martin E. Roth | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary Pagels | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
Korea | | 17. INFORMANT ADDRESS
Helen O. Roth, same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiac arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sepsis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<u>rhabdomyolysis, neuromuscular irritability</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>immediate</u>
<u>7 days</u>
<u>10 days</u> |
| 19a. DATE OF OPERATION
11/26/84 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Perforated ulcer | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. — 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)
— | |
| 21d. INJURY OCCURRED
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
— | | 21f. LOCATION
STREET
CITY OR TOWN
COUNTY
STATE | |
| 22a. I certify that (a) (this hospital) attended the deceased from <u>4/25</u> , 19 <u>84</u> , to <u>12/6</u> , 19 <u>84</u> , that (b) (we) lost saw the deceased <u>12/6</u> , 19 <u>84</u> , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above (d) (we) (did, did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Im Paul Kretting | | DEGREE
MO
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12-7-84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Ira Paul Kretting | | 22e. ADDRESS
2101 Medical Park Dr Silver Spring 20902 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
Dec. 8, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crem. | |
| 23d. LOCATION
CITY OR TOWN
COUNTY
STATE | | 23e. LOCATION
CITY OR TOWN
COUNTY
STATE
Alexandria, Virginia | | | |
| 24. FUNERAL DIRECTOR NAME
Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland 20850 | | 25a. DATE REC'D. BY REGISTRAR
DEC 11 1984 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 4 1 5 6
REG. NO.1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|---|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
DONALD EARLE RUSSELL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 11, 1984 | | | 2b. HOUR
10:50A | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
OCTOBER 19, 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
0 0 0 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
ILLINOIS | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NIH, THE CLINICAL CENTER | | | | 12a. (12a) (12b) (12c) (12d) (12e) (12f) (12g) (12h) (12i) (12j) (12k) (12l) (12m) (12n) (12o) (12p) (12q) (12r) (12s) (12t) (12u) (12v) (12w) (12x) (12y) (12z)
DEFENSE INTELLIGENCE | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. GOVT. | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET ADDRESS / ZIP CODE
12607 EASTBOURNE DR. 20904 | | | 14. FATHER'S NAME
FIRST MIDDLE LAST
EARLE ARTHUR RUSSELL | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ELSIÉ GERSTENBERG | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(IF YES, GIVE WAR OR DATES)
YES WW II | | | 16b. SOCIAL SECURITY NO.
340-01-1015 | | 17. INFORMANT
ADDRESS
ELIZABETH F. RUSSELL (Wife) SAME AS #13 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary failure due to extensive tumor involvement of pericardial sac and lungs
DUE TO, OR AS A CONSEQUENCE OF:
(b) Hemorrhagic ascites (800 ml) with extensive tumor involvement of visceral serosa and omentum
DUE TO, OR AS A CONSEQUENCE OF:
(c) Metastatic tumor in liver
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 26, 1984 to December 11, 1984 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 11, 1984 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Carl E. Freter, M.D.</i> | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/11/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CARL E. FRETER, M.D. | | | 22e. ADDRESS
National Institutes of Health, 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20205 | | | | | | |

| | | | | | | | |
|--|--|------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | | 23b. DATE
12/13/84 | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL CREMATORY | | 23d. LOCATION
SUITLAND PG. MD. | |
|--|--|------------------------------|--|---|--|--|--|

| | | | | | |
|---|--|---|--|--|--|
| 24. FUNERAL DIRECTOR
NAME
RICHARD RAPP, INC.
1804 T ST., N.W., WASH., D.C. 20009 | | 25a. DATE REC'D. BY REGISTRAR
DEC 17 1984 | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Ponder</i> | |
|---|--|---|--|--|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

U.S. GOVT. (INT) REFERENCE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

34157

| | | | | | | | | | |
|--|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
WILFRED SAINT | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DEC. 26, 1984 | | | 2b. HOUR
10:35 A.M. | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
OCT. 30, 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
CANADA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
FAIRLAND NURSING HOME | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CARPENTER | | 12b. KIND OF BUSINESS OR INDUSTRY
SAME | |
| 13a. STATE
MD. | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
10507 GREEN ACRES DRIVE 20903 | |

| | | | |
|---|--|---|--|
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ALFRED SAINT | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ANNIE CHEFF | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
023-09-3149 | |
| 17. INFORMANT
DR. WILFRED SAINT, JR. | | ADDRESS
10507 GREEN ACRES DR. SS | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RENAL Failure
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Nephrosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

| | | | |
|---|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Chronic Longstanding Heart Failure | | | |
|---|--|--|--|

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |

| | |
|--|--|
| 22a. I certify that (I) (the hospital) attended the deceased from 12-30 19 84 to 12-26 19 84 , that (I) (we) lost saw the deceased alive on 12-19 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | |
|--|--|

| | | | | | |
|---|--|---------------------|--|-------------------------------------|--|
| 22b. SIGNATURE
Morton A. Lischner | | DEGREE
MD | | 22c. DATE SIGNED
12/26/84 | |
|---|--|---------------------|--|-------------------------------------|--|

| | | | |
|--|--|--|--|
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Morton A. Lischner | | 22e. ADDRESS
1298 L. W. Barton Drive
Silver Spring, Md | |
|--|--|--|--|

| | | | | | | | |
|---|--|-----------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec. 28, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Geary Washington Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Geary Washington Montgomery Md | |
|---|--|-----------------------------------|--|--|--|---|--|

| | | | | | |
|---|--|--|--|---|--|
| 24. FUNERAL DIRECTOR
NAME
Tokony Funeral Home, 1400 N. ... | | 25a. DATE REC'D BY REGISTRAR
DEC 31 1984 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

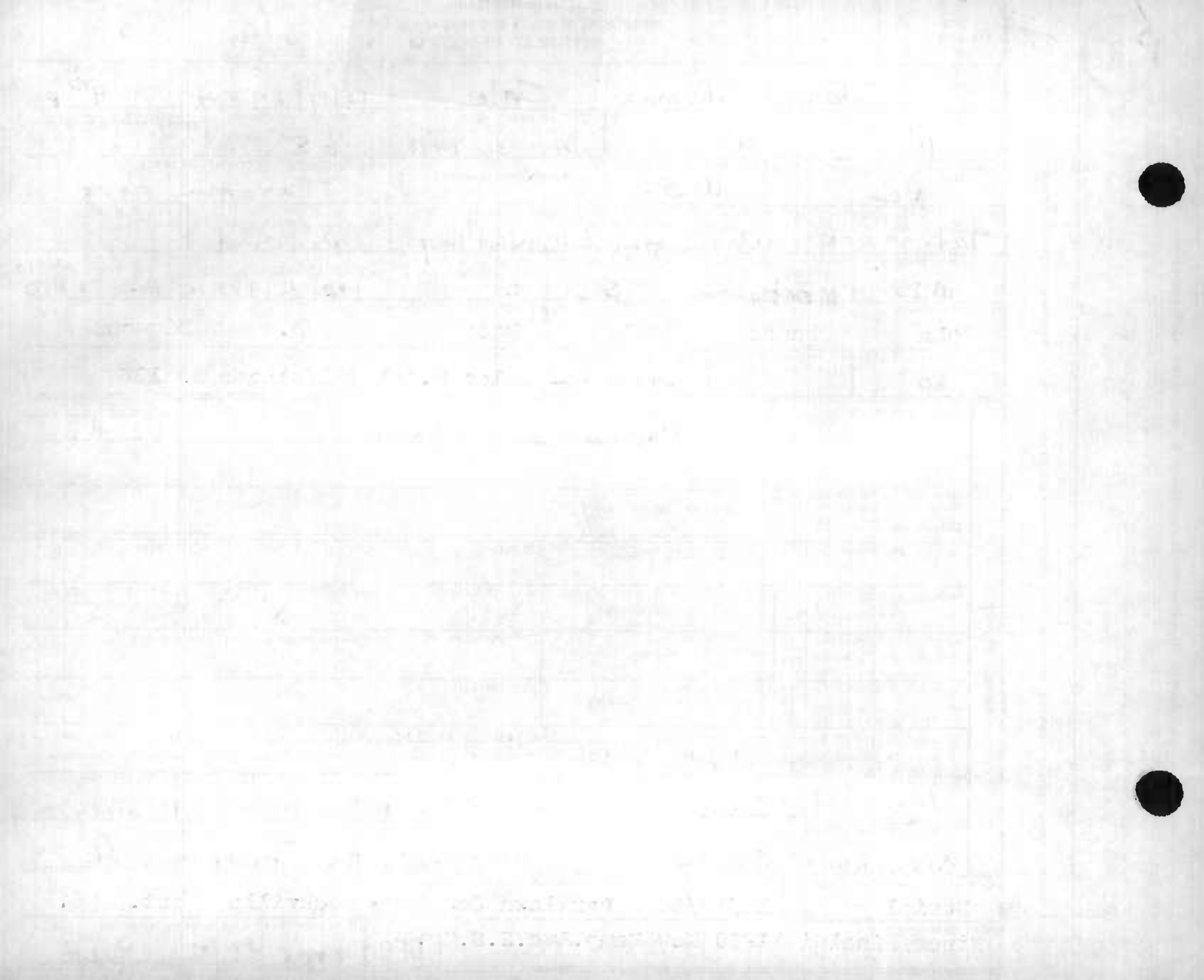
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1- STATE REGISTRAR | | | | STATE OF MARYLAND | | | | 3 4 1 5 8 | | | |
|---|--|--|--|---|--|---|--|--|--|--|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
John Thomas Sale | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12/11/1984 | | | | 2b. HOUR
9 ⁰⁰ P.M. | | | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH MONTH DAY YEAR
4 3 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS | | 7. UNDER 1 YEAR MONTHS DAYS | | 7b. UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NC | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Takoma Park MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
- | | | |
| 13a. STATE
MD | | | | 13b. CITY OR TOWN
Montgomery | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE
142 Ritchie Ave. 55, MD 20912 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
John Thomas Sale | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Rosa B. Simmons | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
243 10 3052 | | 17. INFORMANT ADDRESS
Helen F. Sale (Wife) Same as 13E | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>6 months</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/10</u> , 19 <u>84</u> , to <u>12/11</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>12/11</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Kirkland C. Brace</u> | | | | DEGREE
MD
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12/12/84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Kirkland C. Brace | | | | 22e. ADDRESS
1600 Oakview Ave Takoma Park MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/14/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Rockville Mont. Md. | | | | | |
| 24. FUNERAL DIRECTOR
Hines/Rinaldi | | | | 11800 New Hamp. Ave. S.S. Md | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 13 1984 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson Rendall | |

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be called to report.

Per BC.

1. FOR
STATE
REGISTRAR

12/31/85 Kan

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

34159

REG. NO.

| | | | | | | | | | | |
|---|--|--|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
RICHARD MICHAEL SAMARA | | | 2a. DATE OF DEATH MONTH DAY YEAR
DECEMBER 12 1984 | | | 2b. HOUR
12:26 a | | | | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
DECEMBER 10 1984 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
2 | | 7b. HOUR
MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY County, MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
N/A | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
CHARLES | | 13c. CITY OR TOWN
WALDORF | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
5406 WEDDING COURT 20601 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
RICHARD MICHAEL SAMARA | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
LINDA MARIE STOBER | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) <input type="checkbox"/> IF YES, GIVE WAR OR DATES
NO | | | 16b. SOCIAL SECURITY NO.
N/A | | 17. INFORMANT ADDRESS
RICHARD M. SAMARA, 5406 WEDDING COURT, WALDORF, MD 20601 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) TRACHEO-ESOPHAGEAL FISTULA COMPLICATED BY
DUE TO, OR AS A CONSEQUENCE OF
HYALINE MEMBRANE DISEASE
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
PREMATURITY
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 11, 1984 to DECEMBER 12, 1984 , that (I) (we) last saw the deceased alive on DECEMBER 12, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) _____ the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>J. Nading</i> | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
13 Dec 1984 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J. NADING, LCDR, MC, USNR | | | 22e. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND
NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
December 15, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Trinity Lutheran | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Colebrook, Pennsylvania | | | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland | | | 25a. DATE REC'D. BY REGISTRAR
DEC 18 1984 | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | | | | |

MEDICAL CERTIFICATION

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be received within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove co-bonoppers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 34160

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) HERMAN B. SANDLER | | | 2a. DATE OF DEATH
MONTH 12 DAY 31 YEAR 1984 7b. HOUR 5:00 AM | | |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH MAY DAY 15 YEAR 1905 | 6. AGE
YEARS (LAST BIRTHDAY) 79 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS |
| 7a. BIRTHPLACE
(STATE OR FOREIGN)
RUSSIA | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MANAGEMENT | | 12b. KIND OF BUSINESS OR INDUSTRY
REAL ESTATE |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN SILVER SPRING | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST BEN MIDDLE LAST SANDLER | | | 15. MOTHER'S MAIDEN NAME
FIRST MOLLIE MIDDLE LAST CHERNIAK | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
577-50-4477 | | 17. INFORMANT
ADDRESS
FANNIE SANDLER, 9039 SLIGO CREEK PARKWAY, SILVER SPRING, MARYLAND | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line, but list all causes.)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF Chronic Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO, OR AS A CONSEQUENCE OF | | 18b. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Hours |
|---|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
1. Hypertensive Vascular Disease & Waterbury Metabolic

| | | | |
|---|---|--|--|
| 19a. DATE OF OPERATION
12/30 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
 | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
 P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
 | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
 | |
| 22a. I certify that (1) this hospital attended the deceased from 12/30 , 19 84 , to 12/31 , 19 84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not attend the body after death, so state.) | | | |
| 22b. SIGNATURE
BARTON V. GERSTEN | | 22c. DATE SIGNED
12/31/84 | |
| 22d. PHYSICIAN'S NAME
BARTON V. GERSTEN | | 22e. ADDRESS
50 W. EDMONSTON DR. ROCKVILLE, MD | |

| | | | |
|---|------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | 23b. DATE
1/3/1985 | 23c. NAME OF CEMETERY OR CREMATORY
MOUNT LEBANON CEMETERY | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ADELPHI, PRINCE GEORGE'S, MARYLAND |
| 24. FUNERAL DIRECTOR
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME | | 25. DATE REC'D. BY REGISTRAR
JAN 7 1985 | |
| 26. ADDRESS
232 CARROLL STREET, N. W., WASHINGTON, D. C. | | 27. REGISTRAR'S SIGNATURE
John Davidson | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

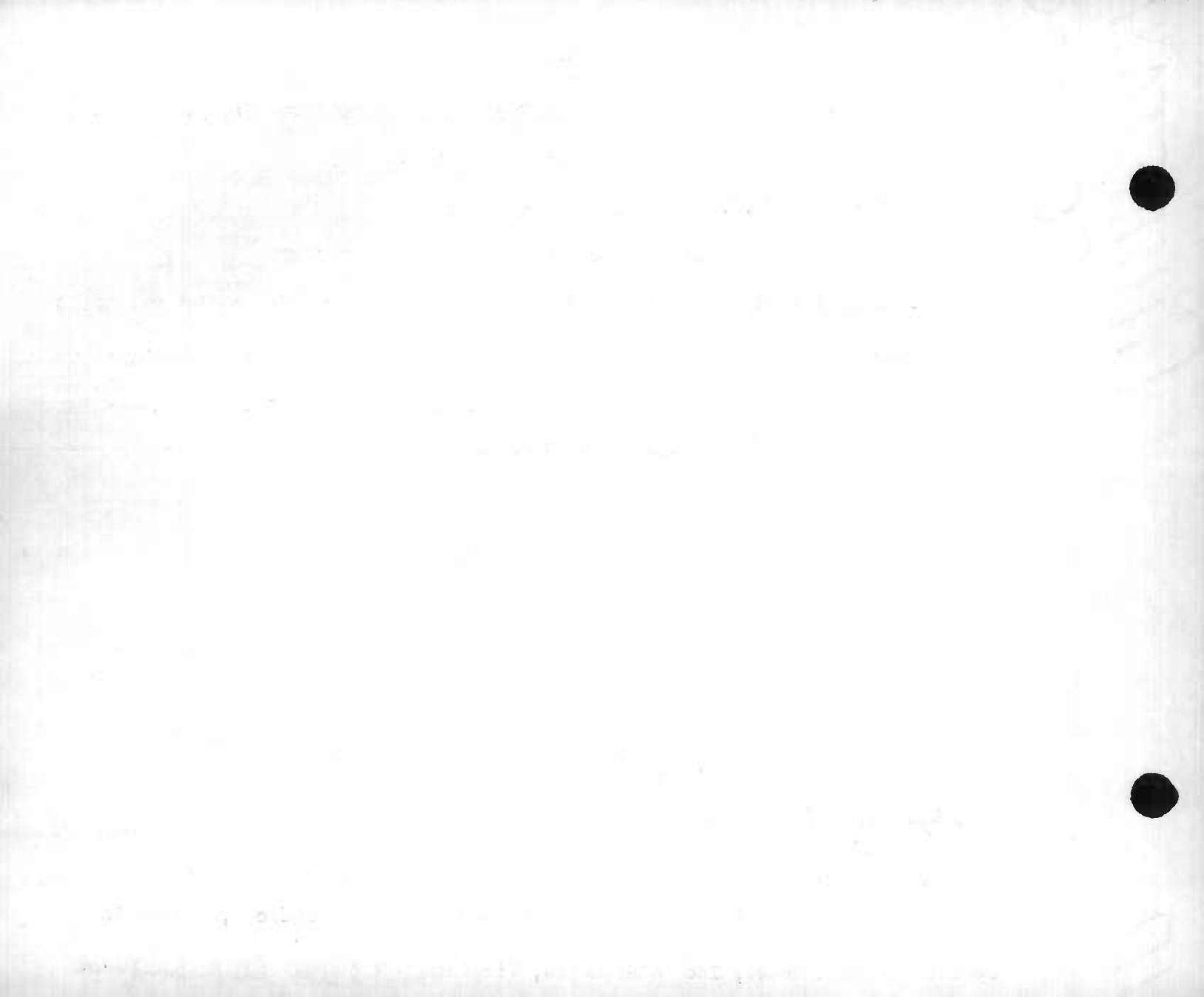
IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

34161

| | | | | | |
|--|---|---|---|---|-----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
ARLEEN SANFORD | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 21, 1984 | | 2b. HOUR
1749 M |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
APRIL 3 1928 | | 6. AGE (IN YEARS LAST BIRTHDAY)
56 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WISCONSIN | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL BETHESDA | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
VIRGINIA FAIRFAX | | 13b. CITY OR TOWN
SPRINGFIELD | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13d. STREET ADDRESS / ZIP CODE
9520 HUNT SQUARE CT. 22153 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
FRED HUPE | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARIA SCHMIDT | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | |
| 16b. SOCIAL SECURITY NO.
390-24-1593 | | 17. INFORMANT
EDNA KNAAK | | ADDRESS
419 WEST MACEE ST. MARSHFIELD WIS. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 21, 1984 to DECEMBER 21, 1984 , that (I) (we) last saw the deceased alive on DECEMBER 21, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
D. L. GRIFFEN, LT, MC, USNR | | DEGREE
MD
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
24 Dec 84 | |
| 22d. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
12/26/84 | 23c. NAME OF CEMETERY OR CREMATORY
Hillside Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Marshfield, Wisconsin | |
| 24. FUNERAL DIRECTOR
NAME
Demaine Funeral Homes, Inc | | ADDRESS
Alexandria, Virginia | | 25a. DATE REC'D. BY REGISTRAR
DEC 31 1984 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | |



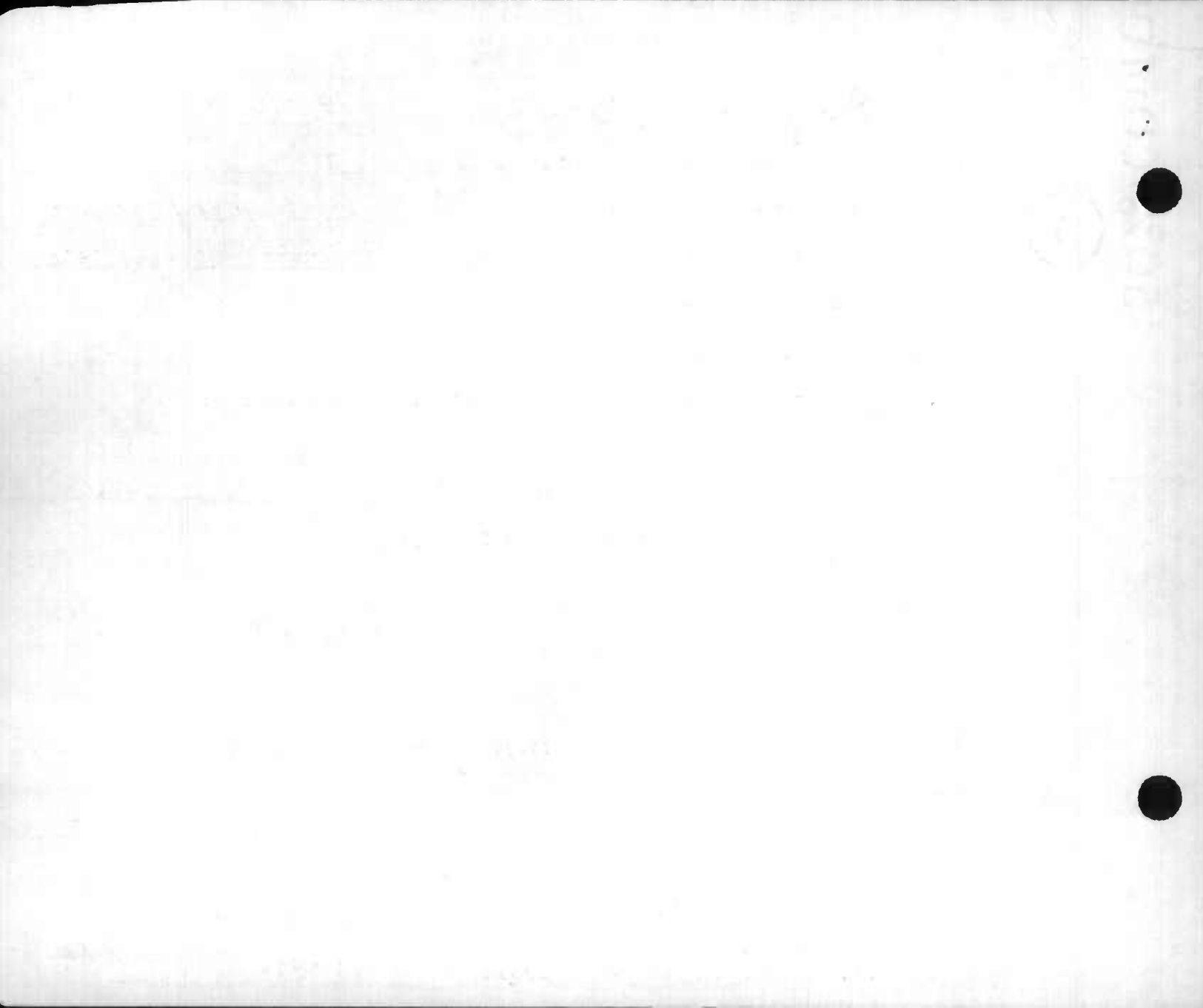
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

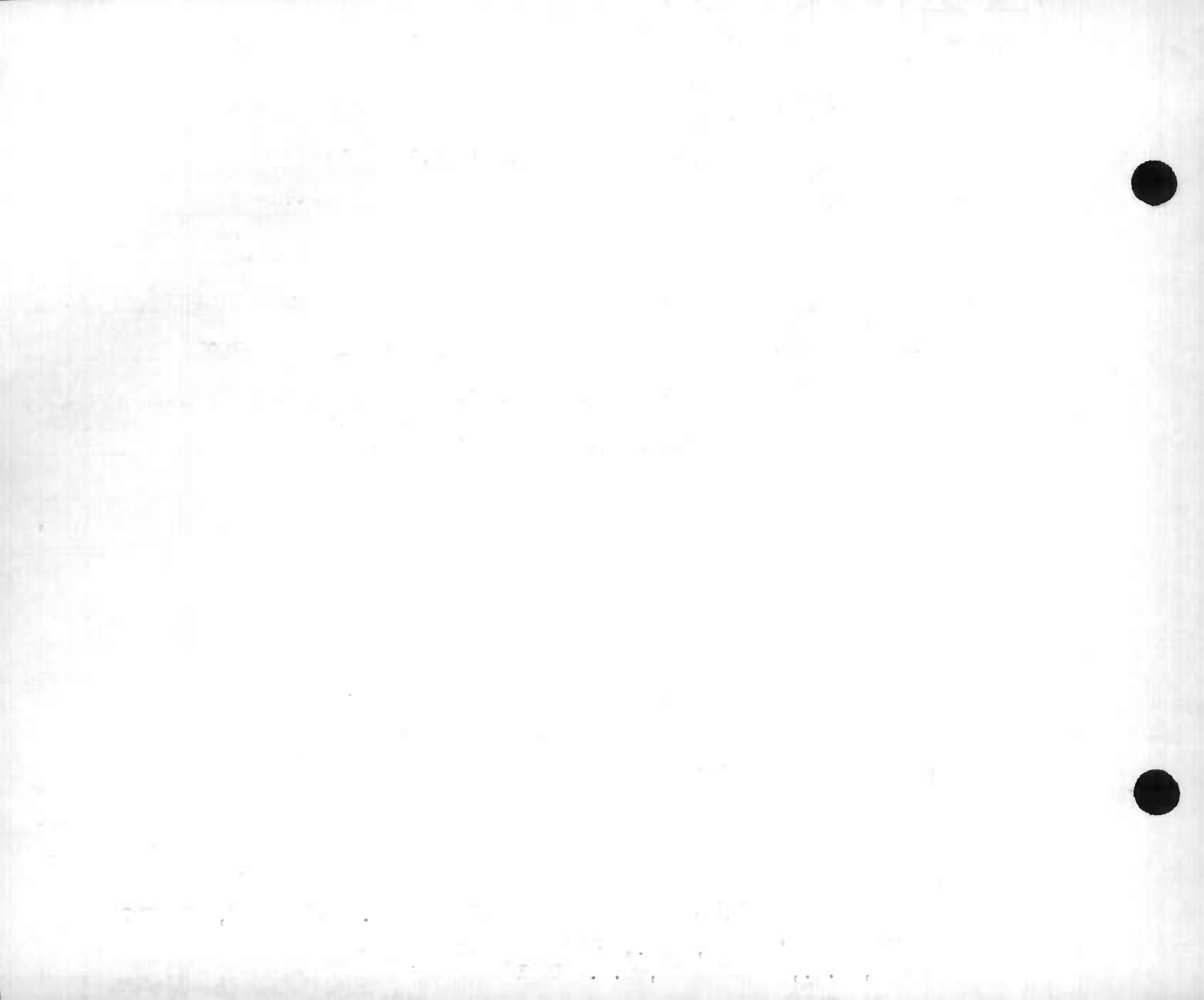
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the attending physician.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 3 4 1 6 2 | |
|--|--|--|--|---|--|---|--|--|--|---|--|
| 1- STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
Margaret K. SAUER | | | | 2a. DATE OF DEATH
12-16-84 | | 2b. HOUR
3:45 P.M. | | | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
Nov. 6, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Connecticut | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Administrative Assistant | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Government | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
11308 Brandy Hall Lane 20878 | | | |
| 14. FATHER'S NAME
FIRST William MIDDLE F. LAST Kelleher | | | | 15. MOTHER'S MAIDEN NAME
FIRST Margaret MIDDLE M. LAST Kennedy | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
152-01-2795 | | 17. INFORMANT
Robert A. Sauer, same as #13 | | ADDRESS | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF (b) myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF (c) coronary heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
15 min
48 hrs
15 yrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-14 , 19 84 , to 12-16 , 19 84 , that (I) (we) last saw the deceased alive on 12-16 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Thomas G. Sinderson, MD | | | | DEGREE
MD | | | | 22c. DATE SIGNED
12-16-84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
THOMAS G. SINDERSON | | | | 22e. ADDRESS
11125 ROCKVILLE PIKE, ROCKVILLE, MD, 20852 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Dec. 20, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring, Maryland | | | | | |
| 24. FUNERAL DIRECTOR
NAME Robert A. Pumphrey ADDRESS Homes, P.A. Bethesda, Maryland 20814 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 18 1984 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | | | |

BP





STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

34164

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
XXXXXXXXXX THELMA CECIL SCHELLBERG | | | 2a. DATE OF DEATH MONTH DAY YEAR
DECEMBER 1, 1984 | | | 2b. HOUR
2³⁰ P M | | | | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
OCT 5, 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
85 | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 9. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | |
| 12. CITY OR TOWN OF DEATH
BETHESDA | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
FERNWOOD NURSING HOME | | | | 14. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CLERK | | 15. KIND OF BUSINESS OR INDUSTRY
GARFINKEL STORE | | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
N/A | | | 13b. CITY OR TOWN
WASHINGTON, D.C. | | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13d. STREET ADDRESS / ZIP CODE
3036 OLIVER ST., N.W. 99999 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JAMES BAKER | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ROSE GREEN | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | | |
| 17. SOCIAL SECURITY NO.
577-05-9450 | | | 18. INFORMANT
NEPHEW
ROBERT W. WINDHAM | | | 19. ADDRESS
12 HESKETH STREET
CHEVY CHASE, MD. 20815 | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*respiratory arrest*APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH*few minutes*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

pseudo dementia

DUE TO, OR AS A CONSEQUENCE OF

(c)

year

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Frankie W. Collins</i> | | | | DEGREE
MD | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22e. ADDRESS | |

| | | | | | | | |
|---|--|-----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12/4/84 | | 23c. NAME OF CEMETERY OR CREMATORY
FT. LINCOLN | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BRENTWOOD PRI GEO MD. | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 6 1984 | | 25b. REGISTRAR'S SIGNATURE
<i>John Davidson</i> | |
| 26. 100 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 3 4 1 6 5
REG. NO. | | | |
|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Jane M. Schultz | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
December 12, 1984 | | | | 2b. HOUR p
1:20 M | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
April 23, 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD | | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
15101 Interlocken Drive | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Francis M. Brinkley | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Margaret Hall | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
577 01 5242 | | 17. INFORMANT
Jacquelyn Mengel
Daughter | | 17b. ADDRESS
10105 Bell Inn Lane
Ellicott City, Md. 21043 | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) HEART ARREST | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
40 HOURS | |
| DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) TOTAL ORGANS' FAILURE | | | | | | | | | | 4 MONTHS | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) LUPUS VASCULITIS | | | | | | | | | | 20 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
none | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from November 4, 19 84, to Dec 12, 19 84, that (I) (we) last saw the deceased alive on Dec 12, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
C Feinstein MD | | | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12 12 84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
C. FEINSTEIN MD | | | | | | 22e. ADDRESS
18 111 Oltney Rd 20832 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Dec 15, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Silver Spring Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME
Robert A. Pumphrey | | | | | | 24b. ADDRESS
P.A., Rockville, Maryland 20850 | | 25a. DATE REC'D. BY REGISTRAR
DEC 18 1984 | | 25b. REGISTRAR'S SIGNATURE
Ike Davidson-Randall | |

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20% COTTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|---|--|---|--|---|--|--|---|---|---|---|--|-------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST <u>Alfred</u> MIDDLE <u>E.</u> LAST <u>Scileppi</u> | | | 2a. DATE OF DEATH
MONTH <u>12</u> DAY <u>4</u> YEAR <u>84</u> | | | 2b. HOUR
<u>1050</u> AM | | | | | | | |
| 3. SEX
<u>MALE</u> | | 4. RACE
<u>CAUCASIAN</u> | | 5. DATE OF BIRTH
MONTH <u>FEB</u> DAY <u>12</u> YEAR <u>1906</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>78</u> YRS. | | 7. IF UNDER 1 YEAR
MONTHS <u></u> DAYS <u></u> | | 8. IF UNDER 24 HRS.
HOURS <u></u> MIN. <u></u> | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>PENNSYLVANIA</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>MONTGOMERY</u> MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
<u>TAKOMA PARK</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>WASHINGTON ADVENTIST HOSPITAL</u> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>BRICK CONSTRUCTION</u> | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE
<u>MARYLAND</u> | | | 13b. COUNTY
<u>MONTGOMERY</u> | | 13c. CITY OR TOWN
<u>SILVER SPRING</u> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
<u>1400 FENWICK LANE</u> | | | 20910 | |
| 14. FATHER'S NAME
FIRST <u>IGNATIUS</u> MIDDLE <u></u> LAST <u>SCILEPPE</u> | | | | 15. MOTHER'S MAIDEN NAME
FIRST <u>ANGILENA</u> MIDDLE <u></u> LAST <u>SARDO</u> | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<u>NO</u> | | | | 16b. SOCIAL SECURITY NO.
<u>067-12-8371</u> | | 17. INFORMANT
ADDRESS
<u>PAULINE SCILEPPI WIFE SAME AS 13</u> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARDIAC, RENAL, PULMONARY FAILURE</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>SEPTIC SHOCK</u> | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>a</u> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/10</u> , 19 <u>84</u> , to <u>12/4</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>12/3/84</u> , 19 <u></u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Louis J. Larca</u> MD | | | | | | 22c. DATE SIGNED
<u>12/4/84</u> | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>LOUIS J. LARCA</u> | | | | | | 22e. ADDRESS
<u>7600 CARROLL AVE TAKOMA PARK, MD</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>BURIAL</u> | | | 23b. DATE
<u>12/7/84</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>GATE OF HEAVEN CEMETERY</u> | | | 23d. LOCATION
CITY OR TOWN <u>SILVER SPRING</u> COUNTY <u>MONT</u> STATE <u>MD</u> | | | | | |
| 24. FUNERAL DIRECTOR
NAME <u>FRANCIS J. COLLINS</u> ADDRESS <u>500 UNIV. BLVD., W. SILVER SPRING, MD. 20901</u> | | | | | | 25a. DATE REC'D. BY REGISTRAR <u>DEC 10 1984</u> 25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u> | | | | | | | |



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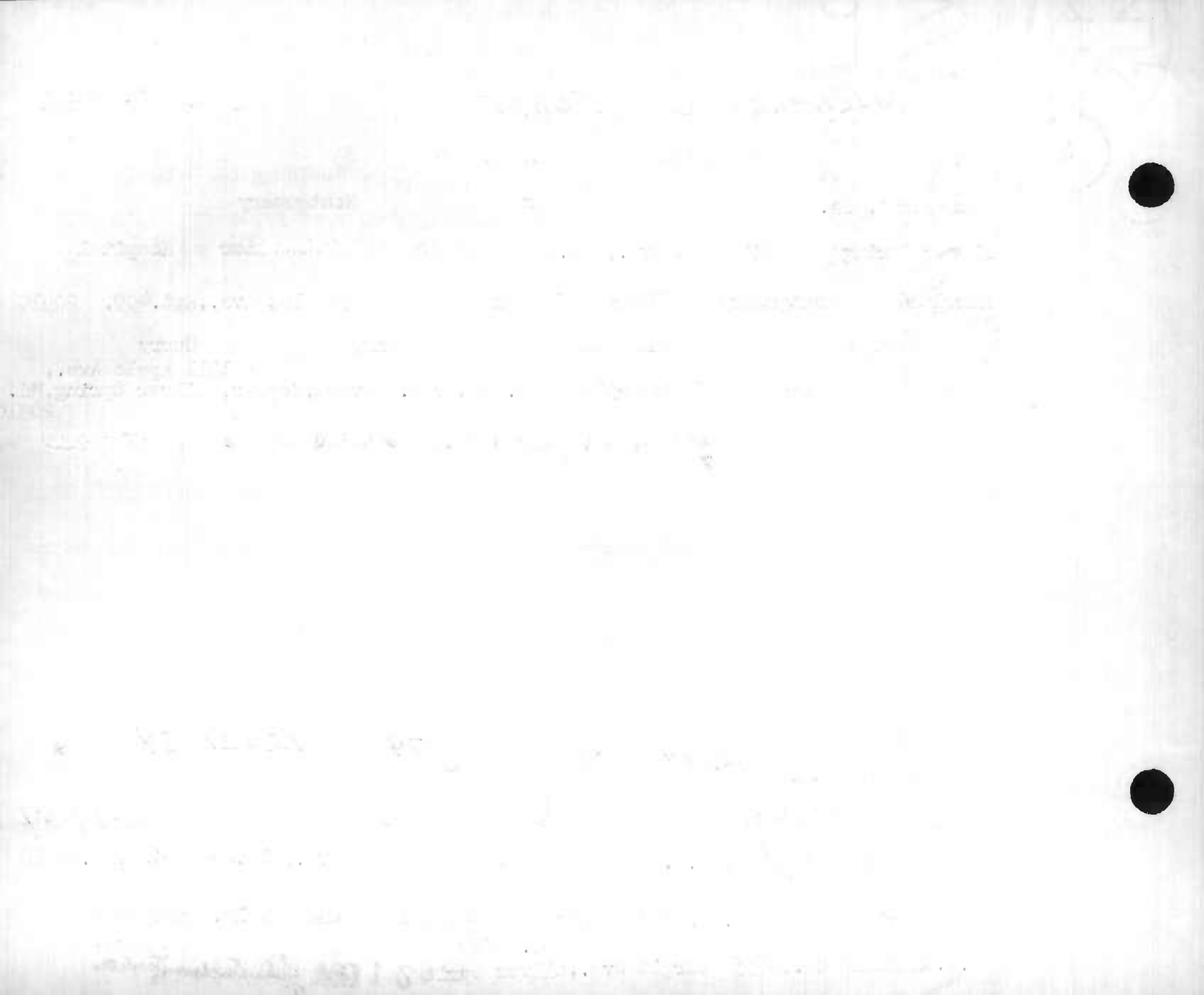
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 34167 | | | |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
MARGARET C. SCOTT | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12 21 84 | | 2b. HOUR
9:25 A.M. | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
Feb. 16, 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS
83 | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Homestead, PA. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
8708 1st Ave., Apt. 409 20910 | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Administrator | | 12b. KIND OF BUSINESS OR INDUSTRY
Hospital | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
George Caldwell | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary Curry | | 13e. STREET ADDRESS / ZIP CODE
8708 1st Ave., Apt. 409, 20910 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
193-01-5768 | | 17. INFORMANT ADDRESS
Mr. Walter C. Devore, Nephew, 1311 Apple Ave., Silver Spring, Md. 20910 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) generalized arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-17 19 84 , to 12-21 19 84 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on 12-17 19 84 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (If <input type="checkbox"/> did not view the body after death. | | | | | | | |
| 22b. SIGNATURE
D. Sengstack M.D. | | | | 22c. DATE SIGNED
12-21-84 | | 22d. ADDRESS
9201 Columbia Blvd., Silver Spring, Md. 20910 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Dec. 24, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Monongahela Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Monongahela, Pennsylvania | |
| 24. FUNERAL DIRECTOR NAME
W.W. CHAMBERS CO., 8655 Georgia Ave., Silver Spring, Md. 20910 | | | | 25. DATE REC'D. BY REGISTRAR
31 1984 | | | |
| 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Rodriguez | | | | | | | |

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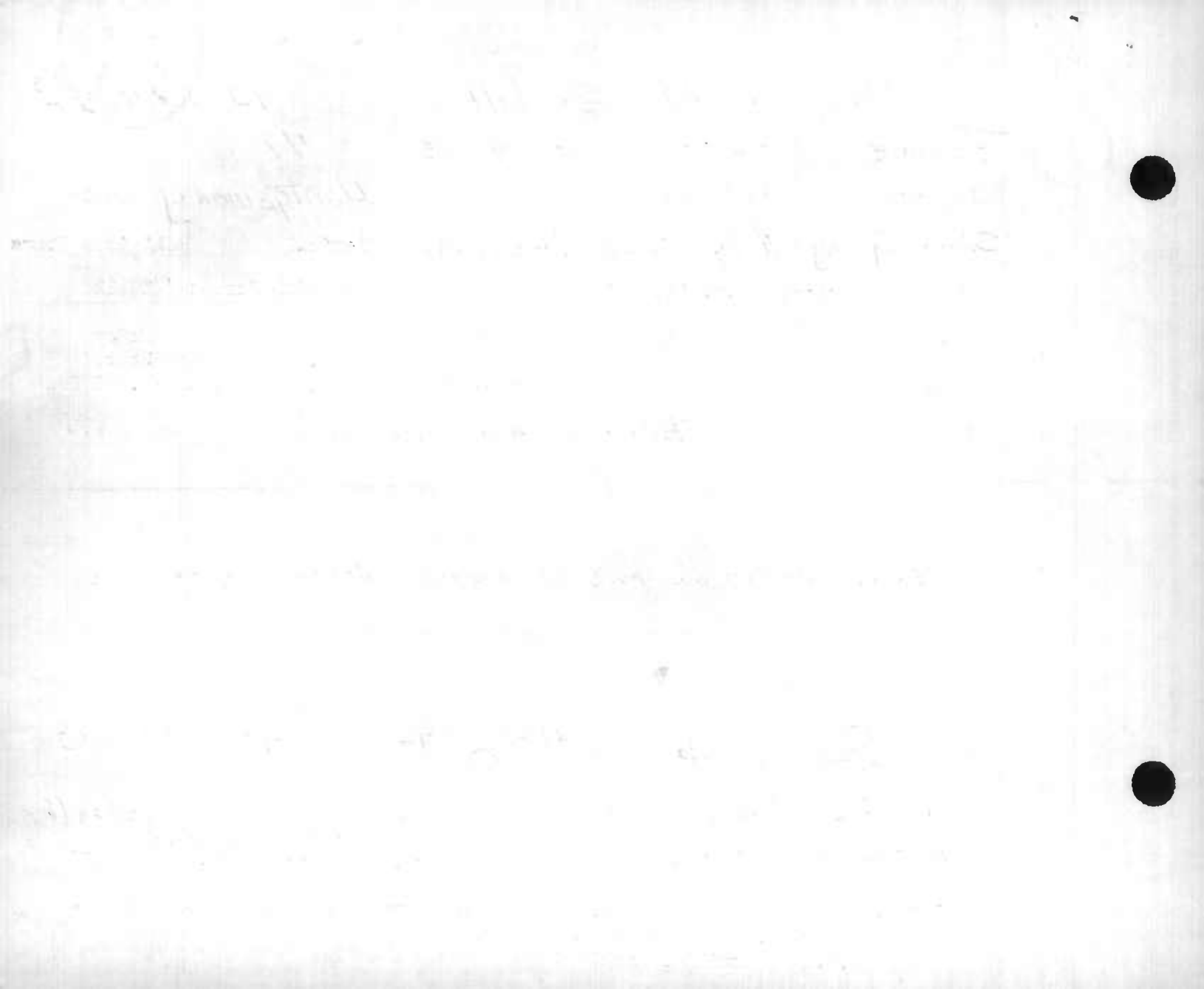
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 34168 | | | | | | |
|---|--|--|---|---|--|--|---|--|---|--|--|---|--|--|-------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | 1. DECEASED NAME (TYPE OR PRINT) Margaret M Seabolt | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 12-20-84 | | | 2b. HOUR 3:55 AM | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR 10-9-05 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7b. CITIZEN OF WHAT COUNTRY? United States | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical | | | 12b. KIND OF BUSINESS OR INDUSTRY Religious Items | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Prince George Mt. Rainier | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 3713 34th Street / 20822 | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William McGaw | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret McCoy | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 577-44-7800 | | 17. INFORMANT Patricia S. Kappian, Daughter,
810 Harrington Road, Rockville, MD. 20852 | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bilateral lobar pneumonia | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH one week. | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) SENILE DEMENTIA AND RESPIRATORY FAILURE | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4/2 1976 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 4/2 1976 to 12/20 1984 , that (1) (we) last saw the deceased alive on 12/20 1984 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (not) view the body after death. | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Martin C. Seabolt DEGREE M.D. | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | 22c. DATE SIGNED 12/20/84 | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN C. SEABOLT | | | | | 22e. ADDRESS 3720 FARRAGUT AVE KENSINGTON MD - 20895 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE December 22, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Maryland | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Robert A. Pumphrey | | | | | ADDRESS Funeral Homes, P.A., Rockville, Maryland | | | | | 25a. DATE REC'D. BY REGISTRAR DEC 24 1984 | | 25b. REGISTRAR'S SIGNATURE John Davidson-Hendall | | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

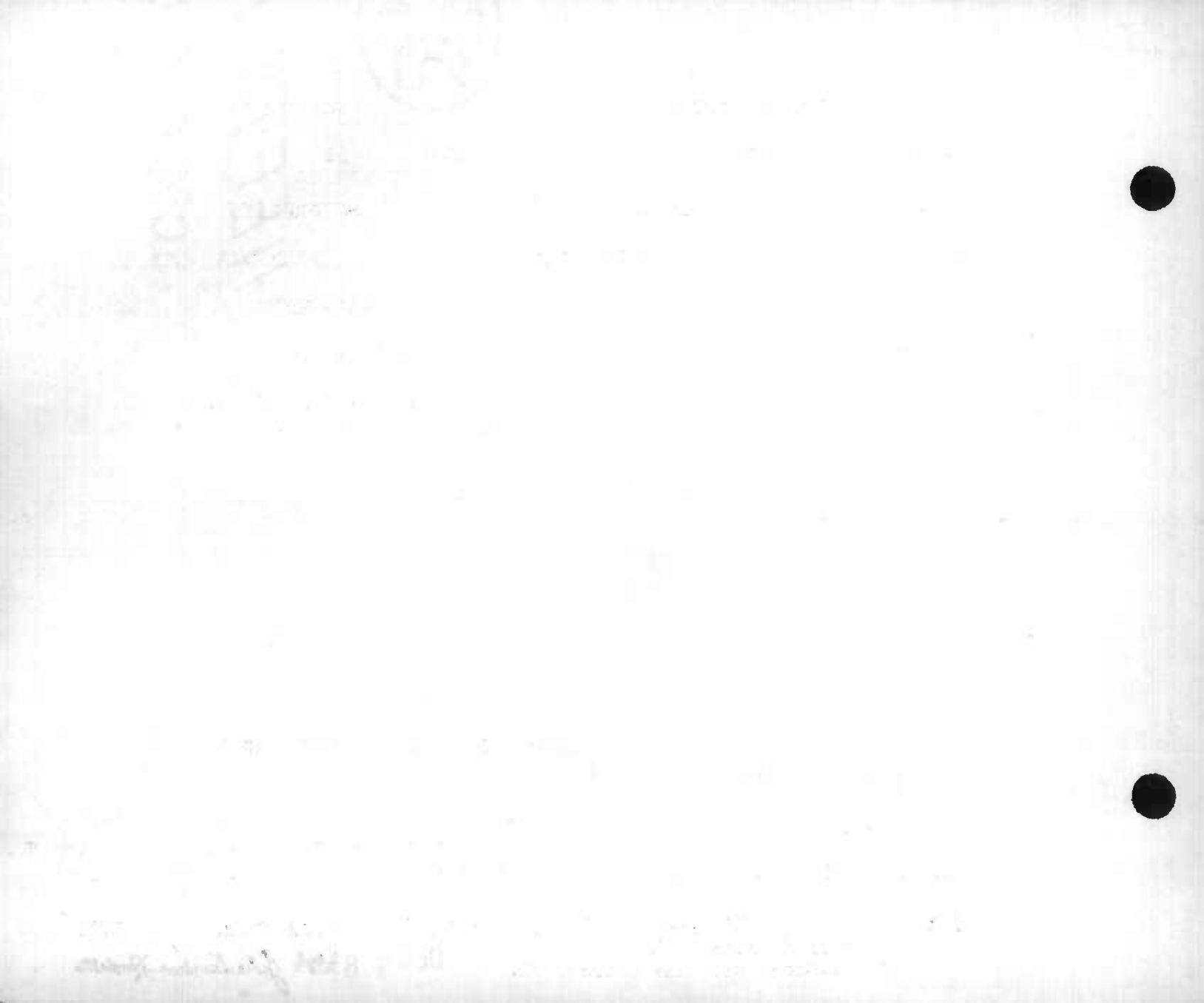
| | | | | | |
|---|--|---|--|---|-----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
JOAN SHIRLEY SEELY | | 2a. DATE OF DEATH MONTH DAY YEAR
DECEMBER 13 1984 | | 2b. HOUR
1:35 P_M | |
| 3. SEX
FEMALE | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH DAY YEAR
APRIL 10 1933 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
51
YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
OHIO | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
VIRGINIA | | 13b. COUNTY
FAIRFAX | 13c. CITY OR TOWN
FALLS CHURCH | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOHN CONGRESSI | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
THELMA ARCURI | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
226-82-5130 | | 17. INFORMANT
ADDRESS
THEODORE A. SEELY, JR., 7415 NIGH ROAD, | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(b) METASTATIC BREAST CANCER
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY, OFFICE FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 6 19 84 , to DECEMBER 13 19 84 , that (I) (we) last saw the deceased alive on DECEMBER 13 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
W. A. DELACEY, LT, MC, USN | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION
CITY OR TOWN COUNTY STATE
NATIONAL CAPITAL REGION, BETHESDA MD 20814 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12/15/84 | | 23c. NAME OF CEMETERY OR CREMATORY
NATIONAL MEMORIAL PARK FALLS CHURCH, VIRGINIA | |
| 24. FUNERAL DIRECTOR
NAME
MURPHY FALLS CHURCH | | 25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
DEC 18 1984 | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows only injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, a physician's injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

34170

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | |
|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) CARL J. SELBO, II | | 2a. DATE OF DEATH
MONTH 12 DAY 3 YEAR 84 | | 2b. HOUR 10 45 AM |
| 3. SEX
MALE | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH February DAY 23 YEAR 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS. |
| 7a. BIRTHPLACE
(COUNTRY)
Wisconsin | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. |
| 10. CITY OR TOWN OF DEATH
Takoma Park | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Executive Financier | 12b. KIND OF BUSINESS OR INDUSTRY
Collections |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY
Pr George's | 13c. CITY OR TOWN
Bowie | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 13e. STREET ADDRESS / ZIP CODE
4005 Welsley Lane 20715 | | 14. FATHER'S NAME
FIRST Carl MIDDLE J. LAST Selbo, I | | |
| 15. MOTHER'S MAIDEN NAME
FIRST Anna MIDDLE Maasberg | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | |
| 16b. SOCIAL SECURITY NO.
387-07-0240 | | 17. INFORMANT
ADDRESS
35 Pine Avenue South Amboy, N.J. 08879 | | |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiopulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF

(b)

metastatic bladder cancer

DUE TO, OR AS A CONSEQUENCE OF

(c)

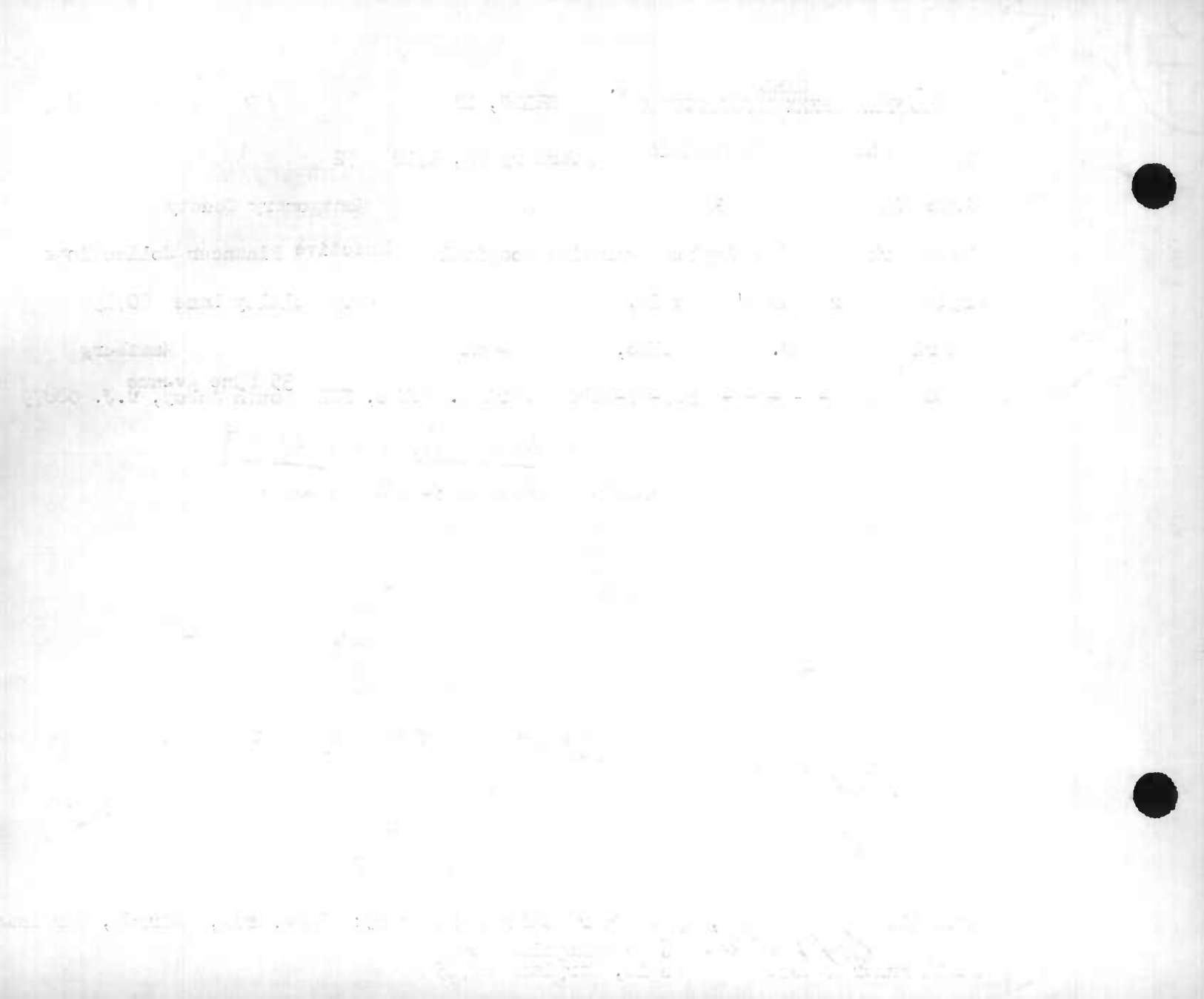
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

MEDICAL CERTIFICATION

| | | | |
|---|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) this hospital attended the deceased from Sept 83 to Dec 3 19 84 , that (I) 0 saw the deceased live on Dec 3 19 84 , and that in (my) 0 opinion death occurred on the date and hour and from the causes stated above, (I) 0 did (did not) view the body after death. | | | |
| 22b. SIGNATURE
D. J. HALDAK, MD | DEGREE
MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
12/3/84 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
D. J. HALDAK, MD | | 22e. ADDRESS
Hyattsville, Md. | |

| | | | |
|--|--|---|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | 23b. DATE
DEC 4, 1984 | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | 23d. LOCATION
CITY OR TOWN Alexandria COUNTY Fairfax STATE Virginia |
| 24. FUNERAL DIRECTOR
NAME
Beall Funeral Home | ADDRESS
16000 Annapolis Road Bowie, Maryland 20715 | 25a. DATE REC'D. BY REGISTRAR
DEC 7 1984 | 25b. REGISTRAR'S SIGNATURE
Julia Bardson-Henderson |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial/transfer permit. Then please remove card/paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 4 7 1

| | | | | | | | | | |
|---|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Joseph H. Sharps | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-28-84 | | | 2b. HOUR
15/1 M | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
10-17-01 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 yrs | | 7. UNDER 1 YEAR
MONTHS DAYS
15/1 | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY
Public Schools | |
| 13a. USUAL RESIDENCE
(IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13a. COUNTY P.G. 13a. CITY OR TOWN Landover | | 13b. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c. STREET ADDRESS / ZIP CODE
9005 Taylor Street 20785 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Richard Sharps | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Francis | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
578-22-8505 | | 17. INFORMANT
Marion R. Sellman | | ADDRESS
2285 Bumpy Oak Rd. LaPlata, Maryland 20646 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cerebrovascular accident
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
48 hr | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
Wernicke's Encephalopathy | | | | | | | | | |
| 19a. DATE OF OPERATION
12/28/84 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Wernicke's Encephalopathy | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, HISTORY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
12/28/84 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT SCHOOL <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
12/28/84 | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
2309 Shorefield Rd Wheaton, MD | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/28/84 to 12/28/84 , that (I) (we) last saw the deceased alive on 12/28/84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Myron L. Lenken MD | | | DEGREE
MD | | | 22c. DATE SIGNED
12/28/84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MYRON L. LENKEN MD | | | 22e. ADDRESS
2309 SHOREFIELD RD WHEATON, MD | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1/2/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Moses Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Lothian Anne Arundel MD | | | |
| 24. FUNERAL DIRECTOR
NAME
ROLLINS FUNERAL HOME, INC. | | | | 25. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
JAN - 1985 [Signature] | | | | | |
| 4339 HUNT PLACE, N.E. | | | | WASHINGTON, D.C. 20019 | | | | | |

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ROLLINS FUNERAL HOME, INC.
4333 HUNT PLACE, N.E.
WASHINGTON, D.C. 20013

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

34172

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Michael Eugene Shaw | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 24, 1984 | | | 2b. HOUR
P
10:45 M | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 15, 1944 | | 6. AGE (IN YEARS LAST BIRTHDAY)
40 | | 7. IF UNDER 1 YEAR
MONTHS DAYS
YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MISSOURI | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NIH, The Clinical Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
PROFESSOR | | 12b. KIND OF BUSINESS OR INDUSTRY
COLLEGE | |
| 13a. STATE
Georgia | | 13b. COUNTY
BULLOCH | | 13c. CITY OR TOWN
Statesboro | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
19 W. Grady St. 30460 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
DENNIS SHAW | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ZETTA SAYLORS | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
378-42-8510 | | 17. INFORMANT
ADDRESS
Mrs. Zetta Shaw, Accent Homes #1, Plattsmouth, Ne. 68048 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-pulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Cerebral toxoplasmosis
DUE TO, OR AS A CONSEQUENCE OF
(c) Acquired immune deficiency syndrome
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION
10/20/84 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 6, 1984 to Dec. 24, 1984 that <input checked="" type="checkbox"/> (we) lost
saw the deceased alive on Dec. 24, 1984 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated
above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Frederic J. Kye | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
12/25/84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Frederic J. Kye | | | 22e. ADDRESS
National Institutes of Health
Clinical Center, Bethesda, Md. 20205 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | | | 23b. DATE
12/25/84 | | 23c. NAME OF CEMETERY OR CREMATORY
METROPOLITAN CREMATORY | | 23d. LOCATION
CITY OR TOWN STATE
ALEXANDRIA, VIRGINIA | | |
| 24. FUNERAL DIRECTOR
NAME
RICHARD RAPP, INC.
1804 T ST., N.W., WASH., D.C. 20009 | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 27 1984 | | 25b. REGISTRAR'S SIGNATURE
Shirley Davidson-Randall | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial or cremation.

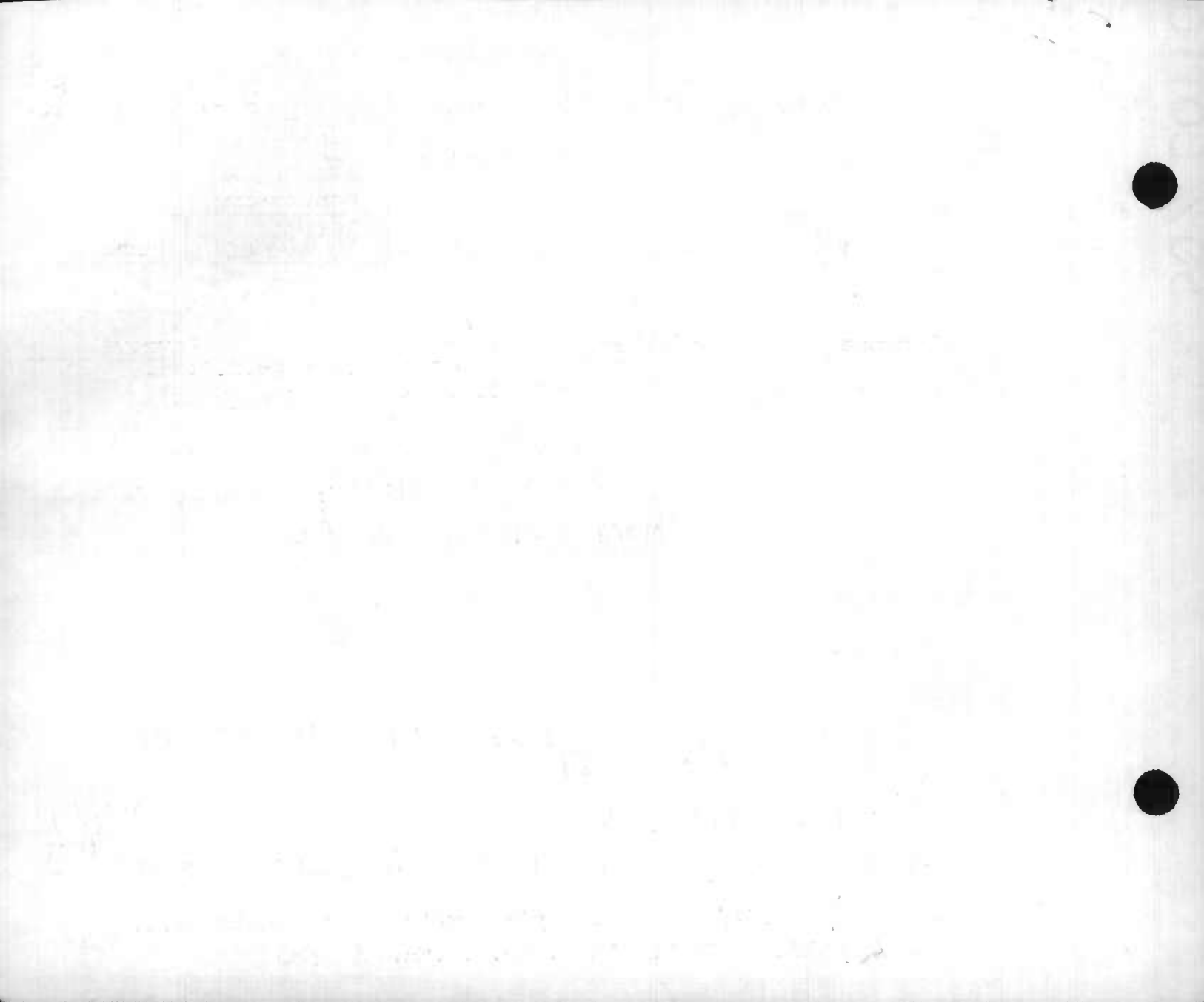
1804 T ST., N.W., WASH., D.C. 20009
RICHARD E. RAY, INC.
TELEPHONE 1502584
ALBANY, ALABAMA, VIRGINIA
ALBANY, ALABAMA, VIRGINIA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|--|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Katherine Mary Sherwood | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-29-84 | | 2b. HOUR
9am | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
12-02-08 | | | | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 6. AGE (IN YEARS, LAST BIRTHDAY)
76 YRS. | | | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Rehired. | | 12b. KIND OF BUSINESS OR INDUSTRY
Nurse | | | | | | | |
| 13a. STATE
md | | 13b. COUNTY
Montgo | | 13c. CITY OR TOWN
S.S. | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Clarence Brinkley | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bertha Barrows | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
579-22-7378 | | 17. INFORMANT
1038 Osage St. S.S. Md.
Margaret Bowman (Daughter) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiopulmonary failure</u>
DUE TO, OR AS A CONSEQUENCE OF:
(b) <u>gastrointestinal bleeding</u>
DUE TO, OR AS A CONSEQUENCE OF:
(c) <u>mixed melanoma tumor</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1 1/2 hr | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/28</u> 19 <u>84</u> to <u>12/29</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>12/28</u> 19 <u>84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Martin D. Meltz | | DEGREE | | 22c. DATE SIGNED
12/29/84 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARTIN D. MELTZ | | 22e. ADDRESS
7525 Greenway Ctr Drum (Greenbelt) MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1/2/85 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Mary's Cemetery | | | | | |
| 24. FUNERAL DIRECTOR
Hines/Rinaldi | | 24b. ADDRESS
11800 New Hamp Ave. S.S. | | 25a. DATE REC'D. BY REGISTRAR
JAN 3 1985 | | | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B, it states any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | | |
|--|--|---|--|--|--|--|--|---|--|--|--|-------------|--|
| 1. FOR STATE REGISTRAR | | 34174 | | | | REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST ALTHA | | MIDDLE nmn | | LAST SHEPARD | | 2a. DATE OF DEATH MONTH DAY YEAR 12 23 84 | | 2b. HOUR 8:10 AM | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 7, 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 | | 7. YRS. MONTHS DAYS | | 8. IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH mon + Gomery MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Housekeeper | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Kensington | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 3000 McComas Ave. 20895 | | | | | |
| 14. FATHER'S NAME Willie | | | | MIDDLE Shepard | | | | 15. MOTHER'S MAIDEN NAME Julia | | | | MIDDLE Grae | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NAME UNKNOWN) No | | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. 300-07-8952A | | 17. INFORMANT ADDRESS Marilyn Hathaway same as 13e | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Arrest | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anterior scabrous heart disease | | | | | | | | | | | | | |
| (c) Diabetes Mellitus. | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes Mellitus | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION 11-15-84 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Shunt grafts | | | | 19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | |
| 21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21c. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-23-84 to 12-23-84, that (I) (we) last saw the deceased alive on 12-21-84, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Robert T. Thibault | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 12-23-84 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT T. THIBAUT | | 22e. ADDRESS Rockville, Md 20852 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/3/85 | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland | | | | | |
| 24. FUNERAL DIRECTOR Tyson Wheeler, Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852 | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 9 1985 | | 25b. REGISTRAR'S SIGNATURE | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR FOR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

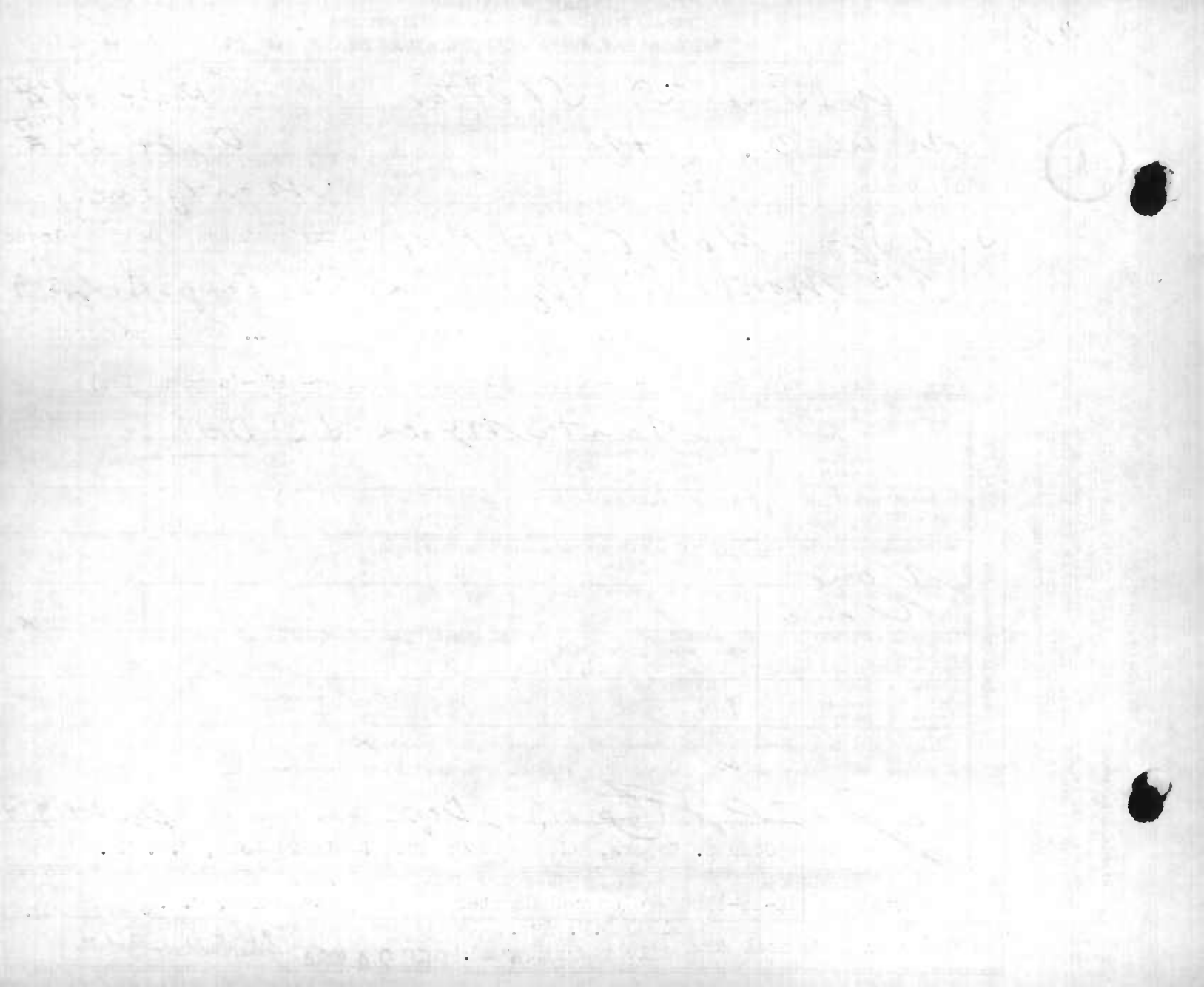
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20M 4/82

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

34175
REG. NO.

| | | | | |
|--|--------------------------------|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Wayne S. Shetler | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR
Dec 24 1984 | | 2b. HOUR
MIN
SEC
8:25 |
| 3. SEX
M | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 27 1907 | 6. AGE (IN YEARS)
LAST BIRTHDAY
76 YRS. | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN
0 0 0 0 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH
S. S. Spr | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holt Cross Hosp | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Poultry Business |
| 13a. STATE
MD | | 13b. COUNTY
Mont | | 13c. CITY OR TOWN
S. S. Spr |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Elias W. Shetler | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna M. Rosenberry | | 12b. KIND OF BUSINESS OR INDUSTRY
Self Employed |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
N/A | | 16b. SOCIAL SECURITY NO.
188-10-0616 | | 17. INFORMANT
ADDRESS
20902
Scarpis Ave, Apt 309 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):
None | | | | |
| 19a. DATE OF OPERATION
None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | |
| ACTUAL SIGNATURE
John S. Rogers | | TITLE (SPECIFY)
M.D. Dep | | DATE
Dec 24 1984 |
| EXAMINER'S NAME
(TYPE OR PRINT)
John S. Rogers, DME | | ADDRESS
1919 Seminary Road, S.S. Md. | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
12-26-1984 | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville Montgomery Md. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Hines/Rinaldi Funeral Home 11800 N.H. Ave., Silver Spring, Md. | | 25a. DATE REC'D. BY REGISTRAR
DEC 24 1984 | | |
| | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Rendell | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 34176

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
AGNES Bryden SHERWOOD | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DEC 5 84 | | | 2b. HOUR
3:35 PM | | | |
| 3. SEX
Female | | 4. RACE
CAUC | | 5. DATE OF BIRTH
MONTH DAY YEAR
02 06 08 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New Jersey | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
BETHESDA HEALTH CENTER | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED TEACHER | | 12b. KIND OF BUSINESS OR INDUSTRY
Education | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE
M.D. | | 13c. COUNTY
MONTGOMERY | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
5819 GREENLAWN DR. 20814 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Elwood Heppard | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret Figge | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(SEE INSTRUCTIONS) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
135 20 9005 | | 17. INFORMANT
Son | | ADDRESS
5819 Greenlawn Drive
Bethesda, Maryland 20814 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebro-vascular accident
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c) Intoxications
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | 18b. INTERVAL BETWEEN ONSET AND DEATH
Instant
years
years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Stroke | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 12/5/84 to date that (1) (we) saw the deceased alive on 12/5/84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (we) view the body after death. | | | | | | | | | |
| 23a. SIGNATURE
Thos G. Ward | | 23b. PHYSICIAN'S NAME (TYPE OR PRINT)
Thos G. Ward | | 23c. ADDRESS
6116 Rockwood Rd Bethesda 20815 | | 23d. DATE SIGNED
12/5/84 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Dec. 9, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodstown Friends Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Woodstown, New Jersey | | | |
| 24. FUNERAL DIRECTOR
NAME
ROBERT A. PUMPHREY | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 10 1984 | | 25b. REGISTRAR'S SIGNATURE
Gula Davidson-Randall | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Item 13 per phone 12/18/84 dad

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 34177

1- FOR STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Hattie W. Shird

2a. DATE OF DEATH MONTH DAY YEAR
12-07-84

2b. HOUR
11:40 AM

3. SEX
Female

4. RACE
Black

5. DATE OF BIRTH MONTH DAY YEAR
03-15-26

6. AGE (IN YEARS LAST BIRTHDAY) YRS
58

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina

7b. CITIZEN OF WHAT COUNTRY?
USA

8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH
MONT. MD.

10. CITY OR TOWN OF DEATH
Kensington, Md.

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Circle Manor

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Domestic

12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
D.C.

13b. CITY OR TOWN
Washington

13c. INSIDE CITY LIMITS? YES ☐ NO ☐

13d. STREET ADDRESS
524 Roxboro Pl., N.W. 99999

14. FATHER'S NAME FIRST MIDDLE LAST

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

16b. SOCIAL SECURITY NO.
224-03-2683D

17. INFORMANT ADDRESS

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cardiovascular Arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Cardiovascular changes
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ AT WORK NOT WHILE ☐ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION CITY OR TOWN COUNTY STATE
12-7-84

22a. I certify that (a) this hospital attended the deceased from 12-28-84 to 12-28-84, that (b) I saw the deceased alive on 12-28-84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (a) did not view the body after death, so state.)

22b. SIGNATURE
Benjamin H. Ruvin, MD

DEGREE
MD

22c. DATE SIGNED
12-7-84

22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Benjamin H. Ruvin, MD

22e. ADDRESS
3720 Farnsworth Ave. Ken. Md 20899

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial Maryland National

23b. DATE
12/14/84

23c. NAME OF CEMETERY OR CREMATORY
Maryland National

23d. LOCATION CITY OR TOWN COUNTY STATE
Laurel P.G. Prince Georges

24. FUNERAL DIRECTOR NAME
J. B. Jenkins Funeral Home

ADDRESS
7474 Landover Rd

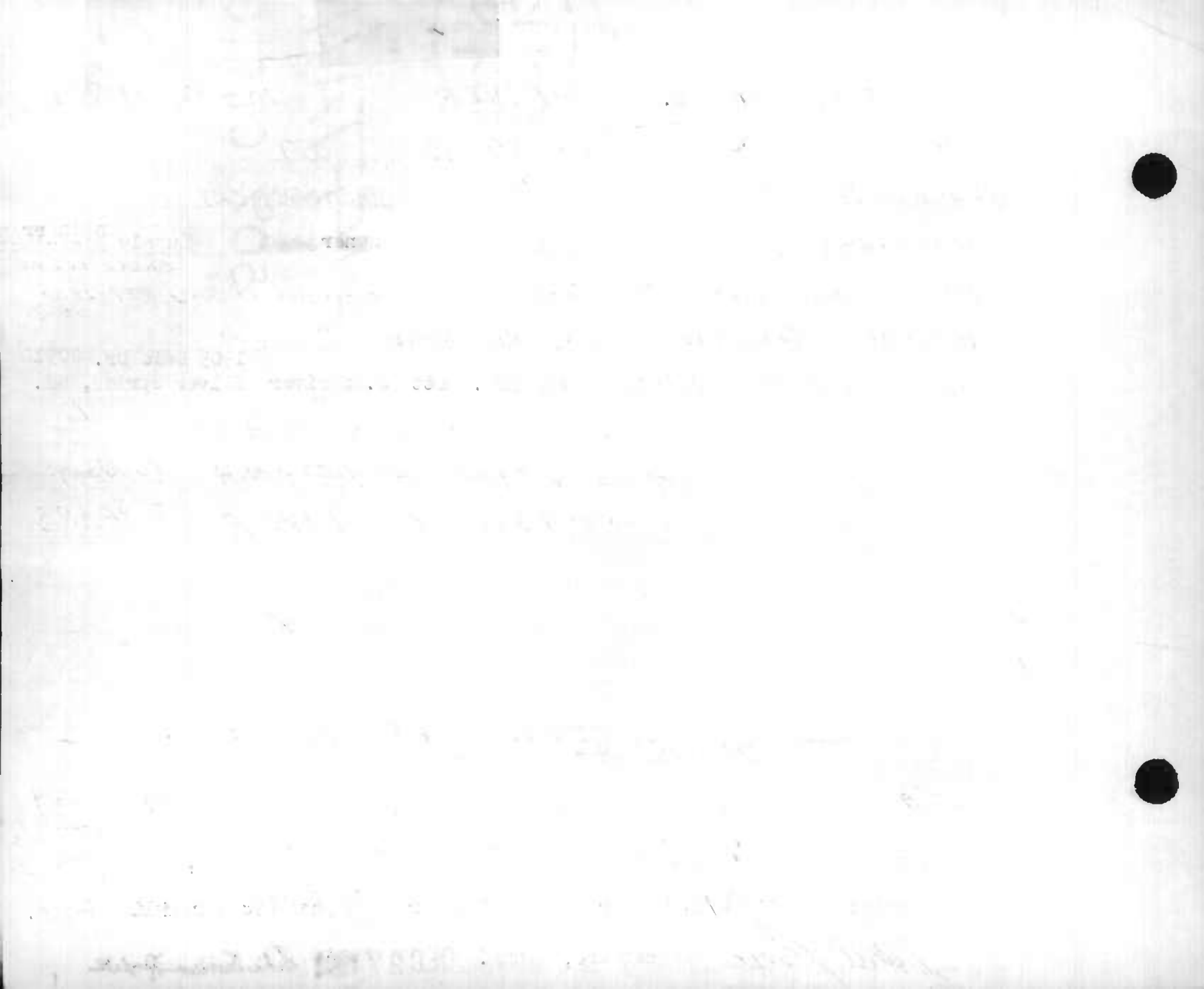
25. DATE RECORDED BY REGISTRAR
DEC 12 1984

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|---|--|---|--|---|---|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | |
| REG. NO. 34178 | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) BENJAMIN E. SHRIVER | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 12-22-84 | | 7b. HOUR 8⁰⁰ A.M. | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 05 15 15 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS. | | 8. IF UNDER 1 YEAR MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WAYNESBORO PA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1505 DALE DRIVE | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner | | 12b. KIND OF BUSINESS OR INDUSTRY Engineering Supply Distributor | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN SILVER SPRING 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 13e. STREET ADDRESS / ZIP CODE 1505 DALE DRIVE MARYLAND 20910 | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST BENJAMIN FRANKLIN SHRIVER | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATHERINE ELDEN | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES (IF YES, GIVE WAR OR DATES) WW II | | | | | 16b. SOCIAL SECURITY NO. 214/34/6861 | | 17. INFORMANT ADDRESS Mrs. Betty J. Shriver Silver Spring, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC ENCEPHALOPATHY | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF (b) MALIGNANT HEPATOMA | | | | | | | | 6 Mos. | |
| DUE TO, OR AS A CONSEQUENCE OF (c) CIRRHOSIS OF LIVER | | | | | | | | 5 YEARS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0 | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from DEC. 13 19 84 to DEC. 22 19 84 , that (I) (we) last saw the deceased alive on DEC. 13 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Marvin Wadler | | | DEGREE M.D. | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/22/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARVIN WADLER | | | 22e. ADDRESS 8218 WISCONSIN AVE Bethesda Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 12/24/1984 | | 23c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Waynesboro Franklin Penna. | | |
| 24. FUNERAL DIRECTOR NAME John E. Goss ADDRESS Waynesboro, Penna. | | | | | 25a. DATE REC'D. BY REGISTRAR DEC 27 1984 25b. REGISTRAR'S SIGNATURE John E. Goss | | | | |



DIVISION OF CAPITAL RECORDS, 201 W/PRESTON ST., BALTIMORE, MARYLAND 21201

Classified by R. Rogers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified above.

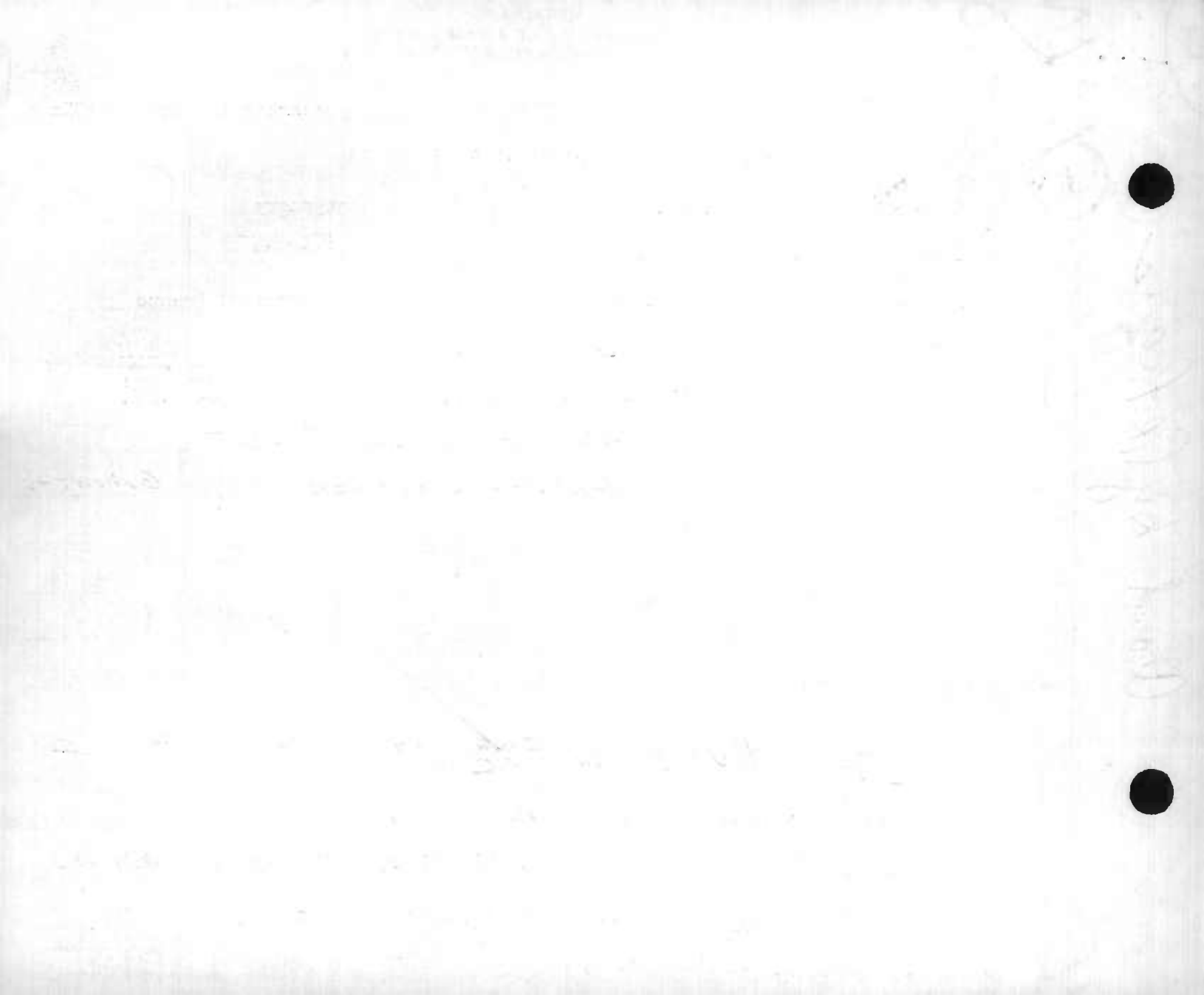
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 34179

FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|---|---|---|--|--|--|--|
| 1. DECEASED NAME
FIRST MIDDLE LAST
GERALDINE EDITH M SILBERT | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 1 1984 | | 2b. HOUR
9:02a M | | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 27 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
CANADA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK OR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
Kensington | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
GERALD MOUSLEY | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ESTHER BRYAN | | | 13e. STREET ADDRESS / ZIP CODE
3606 Farragut Avenue 20895 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
199-18-2054 | | 17. INFORMANT
DONALD T. SILBERT | | | ADDRESS
KENSINGTON, MD 3606 FARRAGUT AVE. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) PANCREATIC CANCER
DUE TO, OR AS A CONSEQUENCE OF (c) 6 MONTHS | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
11:50 P.M. 12 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from JUNE 19 84 to 12/1 19 84 , that (1) <input checked="" type="checkbox"/> I saw the deceased alive on Nov. 15th 19 84 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (We did not view the body after death.) | | | | | | | | | |
| 22b. SIGNATURE
<i>Alan Diamond</i> | | | | | | DEGREE
MD | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ALAN DIAMOND | | | | | | 22e. ADDRESS
1106 SPRING ST, SILVER SPRING, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
CREMATION | | | 23b. DATE
DEC 2, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
METROPOLITAN CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ALEXANDRIA VA | | |
| 24. FUNERAL DIRECTOR
NAME
COLLINS, FRANCIS J. SILVER SPRING, MD | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 6 1984 | | 25b. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

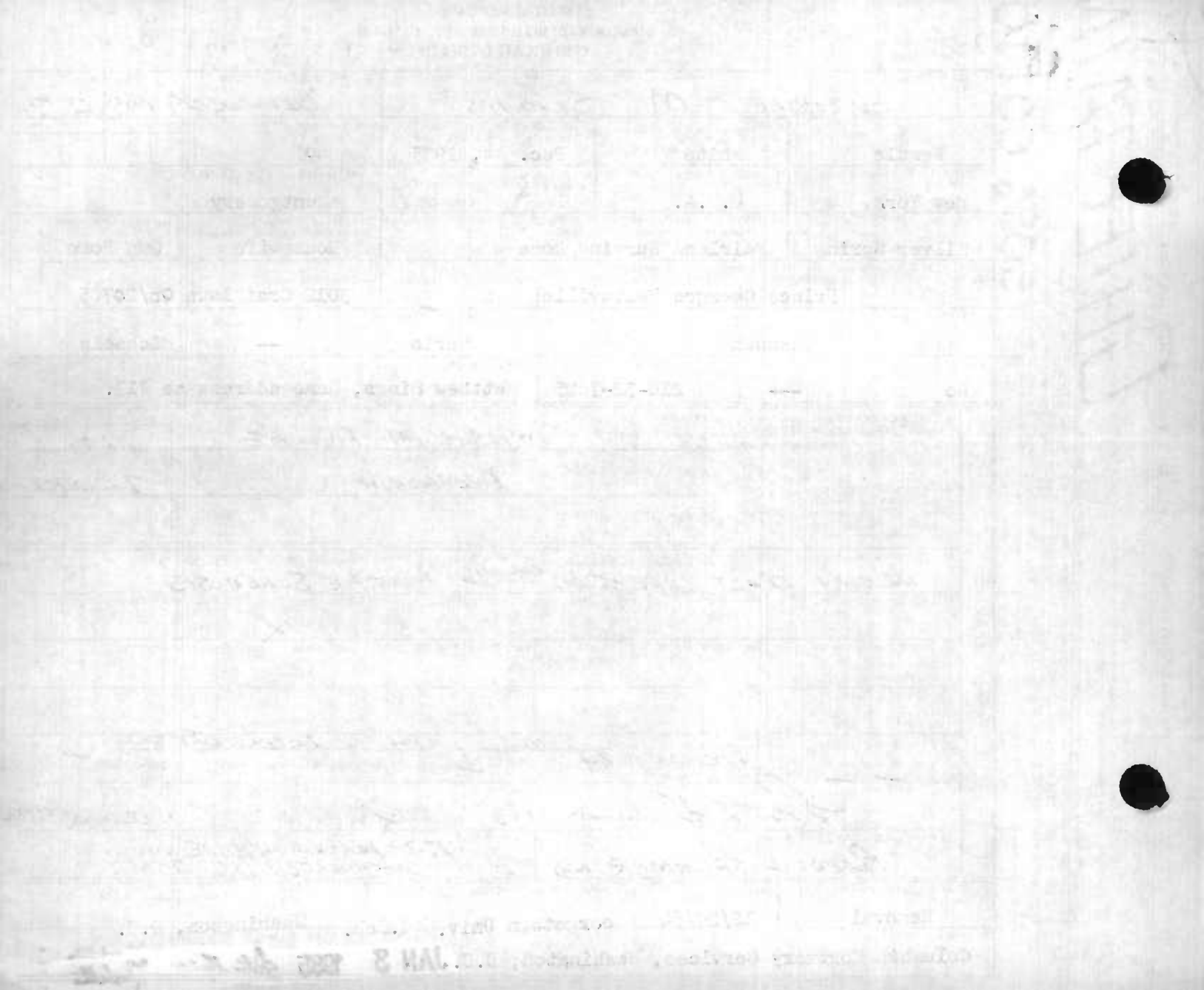
1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
SUZANNE M Simms | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 29 1984 | | | 2b. HOUR
2 A.M. | | | |
| 3 SEX
Female | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 4, 1935 | | 6. AGE (IN YEARS LAST BIRTHDAY)
49 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Fairland Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 13a. STATE
MD | | | 13b. COUNTY
Prince Georges | | 13c. CITY OR TOWN
Beltsville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Unknown | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Marie Michaels | | | 16. SOCIAL SECURITY NO.
218-32-7825 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
218-32-7825 | | | 17. INFORMANT
ADDRESS
Matthew Simms, Same address as #13. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) MYOCARDIAL FAILURE
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 DAY
7 WEEKS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) URINARY TRACT INFECTION CHRONIC MULTIPLE SCLEROSIS | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from NOV 19 84 to DECEMBER 29 84 , that (I) (we) last saw the deceased alive on December 11, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Robert L. Krichmar M.D. | | | | DEGREE
M.D.
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
December 29 1984 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT L. KRICHMAR M.D. | | | | 22e. ADDRESS
7733 Maska Avenue N.W.
WASHINGTON D.C. 20012 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | 23b. DATE
12/29/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Georgetown Univ. Med. Sch. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington D.C. | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Columbia Mortuary Services, Washington, D.C. | | | | | | | | | |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 4 1 8 1
REG. NO.

| | | | | | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|---------------------|--|-------------------------|--|--------------------------------------|--|----------|--|
| 1- STATE REGISTRAR | | 2- DECEASED NAME
(TYPE OR PRINT) | | FIRST Simon | | MIDDLE C | | LAST Skeels | | 2a. DATE KNOWN OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| | | Simon | | C. | | | | SKEELS | | ESTIMATED | | 12, 22, 1984 | | 2:09 PM | |
| 3- SEX | | 4- RACE | | 5- DATE OF BIRTH | | 6- AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| male | | White | | 01 25 1896 | | 88 YRS. | | | | | | 12/22 1984 | | 2:09 PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8- MARRIED | | NEVER MARRIED | | WIDOWED | | DIVORCED | | 9- BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Iowa | | U.S.A. | | | | | | | | | | MONTGOMERY | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Bethesda, MD | | Suburban Hospital | | Engineer | | U.S. Gov't. | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | |
| MD | | MONTGOMERY | | BETHESDA | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 5108 WORTHINGTON Dr | | | | | | 20816 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | |
| Augustus L. Skeels | | Mary A. Barkley | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | |
| Yes | | W.W.1 | | 579-34-7408 | | Mrs. Mary B. Skeels | | AS #13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART 1 DEATH WAS CAUSED BY: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| 8159 | | IMMEDIATE CAUSE (a) CARDIO PULMONARY FAILURE | | ACUTE | | | | | | | | | | | |
| | | (b) MULTIPLE TRAUMA | | 18 DAYS | | | | | | | | | | | |
| | | (c) | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | | | | | | | |
| 14/6/84 | | PNEUMOTHORAX CHEST TUBE | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | HIT TREE SINGLE CAR ACCIDENT | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | | | | | | | | | |
| | | STREET | | LITTLE FALLS Pkwy, BETHESDA MONT MD | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | | | | | | |
| death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | | | | | |
| Francis C. Mayle | | M.D. Dept | | 12/22/84 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | | | |
| Francis C. Mayle | | 8200 Wisconsin Ave NW Bethesda MD | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | | | | | |
| Burial | | Dec. 27, 84 | | Evergreen Cemetery | | Red Oak, Iowa | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| NAME | | ADDRESS | | | | | | | | | | | | | |
| Jos. Gawler's Sons | | 5130 Wisc. Ave Wash. DC | | DEC 31 1984 | | Julia Davidson-Randall | | | | | | | | | |



NEW 31 KSA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director, page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 34182 | |
|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) <i>Ilya</i> | | 2a. DATE OF DEATH MONTH DAY YEAR <i>12-21-84</i> | |
| 3 SEX <i>Male</i> | | 4 RACE <i>White</i> | | 5 DATE OF BIRTH MONTH DAY YEAR <i>3 29 14</i> | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Lithuania</i> | | 7b CITIZEN OF WHAT COUNTRY? <i>Stateless</i> | | 6 AGE (IN YEARS LAST BIRTHDAY) <i>70</i> YRS. | |
| 8 CITY OR TOWN OF DEATH <i>Takoma Park</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hosp.</i> | | 9 BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD. | |
| 12a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <i>Maryland</i> 13b COUNTY <i>Montgomery</i> 13c CITY OR TOWN <i>Sil. Spg.</i> | | 12b USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Engineer (Ret.)</i> | | 12c KIND OF BUSINESS OR INDUSTRY <i>Mechanical</i> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST <i>Wolff Skurkovich</i> | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Esther Levin</i> | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | 16b SOCIAL SECURITY NO. <i>None</i> | | 13e STREET ADDRESS <i>12305 Featherwood Drive</i> | |
| 17 INFORMANT ADDRESS <i>Silver Spring, Md</i> | | 17 INFORMANT <i>Genia Skurkovich; 12305 Featherwood Dr</i> | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIOPULMONARY ARREST</i> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>CARDIOGENIC SHOCK</i> | | | | <i>24 hrs</i> | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>MYOCARDIAL INFARCTION</i> | | | | <i>Admission MI + 24-48 hrs</i> | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21c INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21d PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21e LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from <i>12/14/84</i> , 19 <i>84</i> , to <i>12/21</i> , 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>12/21</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE <i>Louis J Larca</i> MD | | | | 22c DATE SIGNED <i>12-21-84</i> | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>LOUIS J LARCA</i> | | | | 22e ADDRESS <i>7600 CARROLL AVE Takoma Park, MD</i> | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b DATE <i>12-23-1984</i> | | 23c NAME OF CEMETERY OR CREMATORY <i>Mt. Lebanon Mem. Park Hyattsville, Md.</i> | |
| 24 FUNERAL DIRECTOR NAME <i>Danzansky-Goldberg Chapels; 1170 Rockville Pike</i> | | 24b DATE REC'D. BY REGISTRAR <i>DEC 31 1984</i> | | 24c REGISTRAR'S SIGNATURE <i>J. Davidson</i> | |

BP

7-7-18

1000

1000



1000 1000 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner (not) because of that etc.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|---|---|---|--|--|---|---|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. 34183 | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
JEAN MARGULIES SLAVIN | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
Dec. 20, 1984 | | | 2b. HOUR
1:30pM | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
May 15, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Russia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Chevy Chase | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bethesda Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
----- | | |
| 13a. STATE
Maryland | | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Sil. Spg. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
578-50-7227A | | 17. INFORMANT ADDRESS
Ethel Gorin; 3051 Albemarle St. NW, D.C. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Left cerebral hemisphere infarct | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 Months | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerotic cerebrovascular dis. | | | | | | | | | years | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) Hypertension | | | | | | | | | years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) XXXXXX attended the deceased from June 19 68, to Dec. 20 19 84, that (I) (we) last saw the deceased alive on Dec. 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <i>Jason Geiger</i> | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12-20-1984 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JASON GEIGER, M.D. | | | 22e. ADDRESS
8830 Cameron Street; Silver Spring, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12-23-1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Adas Israel Cem. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Washington, D.C. | | | |
| 24. FUNERAL DIRECTOR NAME
Danzansky-Goldberg Chapels; | | | 24b. ADDRESS
1170 Rockville | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>Julia...</i> | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Effie E. Smith | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/19/84 | | 2b. HOUR
6³⁰ A M | | |
| 3. SEX
F | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 21 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. CITY OR TOWN
Carroll Sykesville | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS
7 Schneider Dr. 21784 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William M. Tayman | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Jane Bryant | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE YEAR OR DATES)
N/A | | 17. INFORMANT
William Smith | | | ADDRESS
Same as #13c | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(b) CHRONIC RENAL FAILURE years
DUE TO, OR AS A CONSEQUENCE OF
(c) DISSEMINATED INTRAVASCULAR COAGULATION 2d | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
HYPERTENSION | | | | | | | | | |
| 19a. DATE OF OPERATION
none | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
none | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-1 19 84 , to 12-19 19 84 , that (I) (we) last saw the deceased alive on 12-19 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
C. Feinstein MD | | | | | DEGREE
MD | | 22c. DATE SIGNED
12 19 84 | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
C. FEINSTEIN MD | | | | | 22e. ADDRESS
18111 PRINCE PHILIP Dr OLNEY MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/22/84 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Thomas Ch. Cem. Green | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Pg. Md. | | | |
| 24. FUNERAL DIRECTOR
FLECK FUNERAL HOME INC.
7601 Sandy Spring Rd. Laurel Md. | | | | | 25a. DATE RECEIVED
12-20-84 | | 25b. REGISTRAR'S SIGNATURE | | |

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100% COTTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

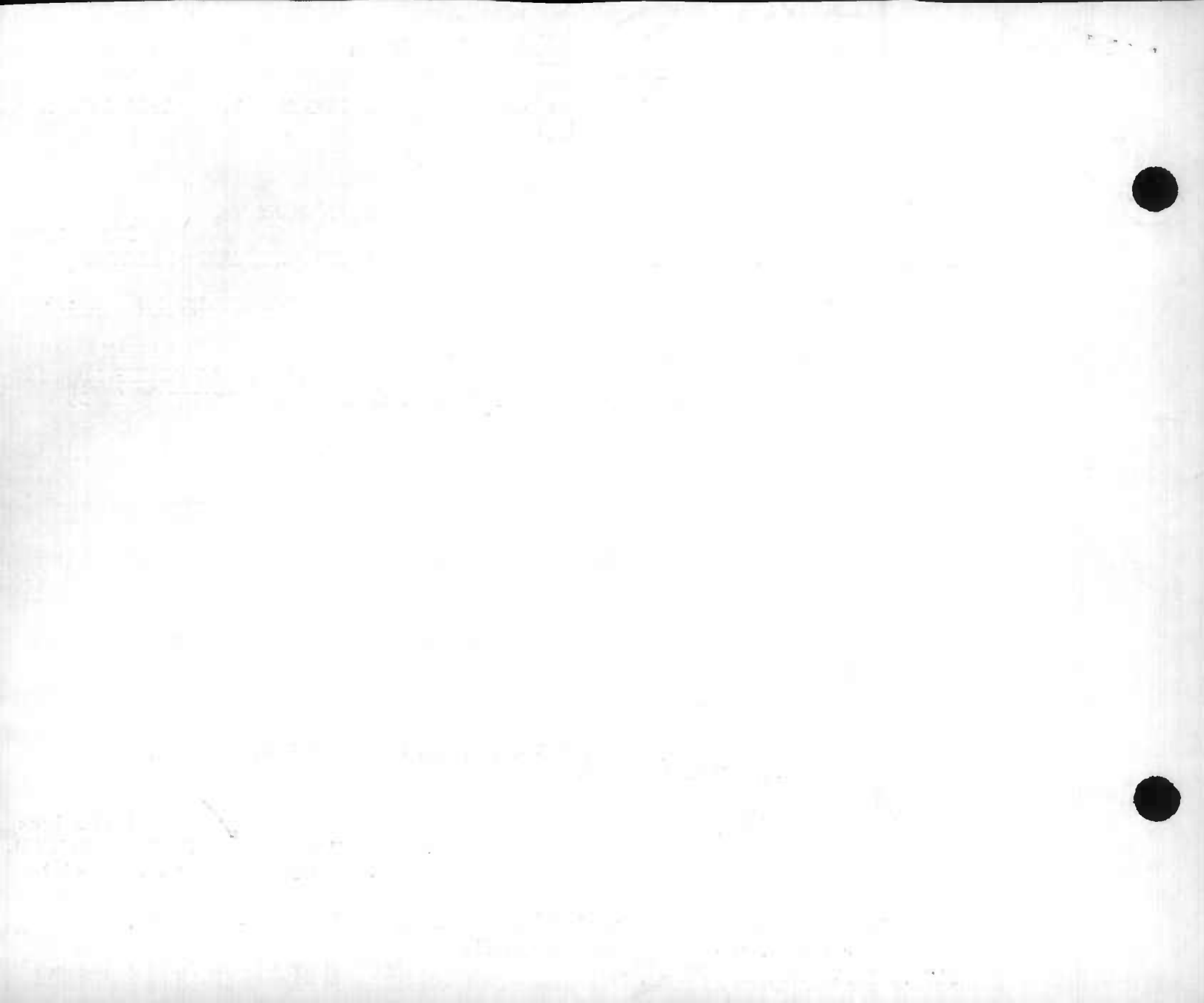
IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 34185

| | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH | | | MONTH DAY YEAR | | | 7b. HOUR | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | DECEMBER 1, 1984 | | | 6:11 A _M | | |
| GRACE CECILIA SMITH | | | | | | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | |
| FEMALE | | | CAUCASIAN | | | MONTH DAY YEAR
SEPT 14 1931 | | | 53 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| PENNSYLVANIA | | | UNITED STATES | | | | | | MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BETHESDA | | | NAVAL HOSPITAL | | | ADMIN ASSISTANT | | | SCIENTIFIC RESEARCH | | |
| 13a. STATE | | | 13b. CITY OR TOWN | | | 13c. INSIDE CITY LIMITS? | | | 13d. STREET ADDRESS / ZIP CODE | | |
| MARYLAND | | | CALVERT | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 3321 HOLLANDCLIFF RD 20639 | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| FIRST MIDDLE LAST
JOHN BERNARD BERRY | | | FIRST MIDDLE LAST
CECILIA MARGARET LANGAN | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | |
| NO | | | 577-40-3814 | | | NICHOLAS M. SMITH HUNTINGTOWN, MD 20639 | | | 3321 HOLLANDCLIFF RD | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SMALL CELL CARCINOMA OF THE LUNG | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 27, 19 84, to DECEMBER 1, 19 84, that (I) (we) lost
saw the deceased alive on DECEMBER 1, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 21f. SIGNATURE | | | DEGREE | | | 22c. DATE SIGNED | | | | | |
| GARY ZALOGA | | | MD | | | 1 DEC 1984 | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22d. ADDRESS | | | | | | | | |
| GARY ZALOGA | | | NAVAL HOSPITAL, NAVAL MEDICAL COMMAND,
NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | |
| CREMATION | | | DEC. 3, 1984 | | | METROPOLITAN CREMATORY | | | ALEXANDRIA VA. | | |
| 24. FUNERAL DIRECTOR'S NAME | | | 24b. ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| FRANCIS J. COLLINS | | | 500 UNIVERSITY BLVD., WEST, SILVER SPRING, MD | | | DEC 6 1984 | | | Julia Davidson-Randall | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called for post-mortem.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 3 4 1 8 6 | |
|---|--|---|--|---|--|--|---|---|--|-----------|--|
| 1 - FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
LOUIS SMITH | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 21 84 | | | 2b. HOUR
2 45
A M | | | |
| 3 SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 13, 1888 | | 6. AGE (IN YEARS LAST BIRTHDAY)
96 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
England | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Unknown | | 12b. KIND OF BUSINESS OR INDUSTRY
Unknown | | | |
| 13a. STATE
Md. | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
6105 Montrose Road 20852 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Daniel Bovinsky | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Jane Yudol | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
579-60-9355 | | 17. INFORMANT
NAME ADDRESS
Max M. Goldberg (Personal Representative)
#51 Monroe Street Rockville, Md. 20850 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a
<u>Alzheimer's disease</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. " 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY OFFICE FARM ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 17</u> , 19 <u>84</u> to <u>Dec 21</u> , 19 <u>84</u> , that (I) (we) lost
saw the deceased alive on <u>Dec. 20</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Barbara Blaylock, M.D.</u> | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12-21-84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Barbara Blaylock, M.D.</u> | | | | | | 22e. ADDRESS
<u>6111 Executive Blvd. Rockville, Md. 20852</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | | 23b. DATE
12/21/84 | | 23c. NAME OF CEMETERY OR CREMATORY
George Wash. Med School | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D.C. | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Columbia Mortuary Services, Inc.
225 Missouri Ave. N.W. Wash. D.C. 20011 | | | | | | 25. DATE RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
DEC 27 1984 Julia Davidson | | | | | |



| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 34181 | |
|--|--|-------------------------|--|--|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Bertha S. Spatz | | | | | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED Dec 4, 1984 | | 2b. HOUR
4:30 PM | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR Aug 14 1915 | | 6. AGE
(IN YEARS) LAST BIRTHDAY 69 YRS. | | 7. UNDER 24 HRS.
MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD
Dec 5, 1984 | | 7d. HOUR
8 PM | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery, MD. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Univ. N. H. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
----- | | | |
| 13a. STATE
MD | | | | 13b. COUNTY
Montgomery | | | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Louis Stark | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ida Denowitch | | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | | |
| 16a. SOCIAL SECURITY NO.
579-07-3133 | | | | 17. INFORMANT
Don A. Engel; 818 Hyde Court | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Liver
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).
None | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
10-27-84 | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
Fract. l. hip | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
John S. Rogers | | | | TITLE (SPECIFY)
Dep. | | | | MEDICAL EXAMINER
DR. JOHN S. ROGERS | | | | DATE SIGNED
Dec 4/1984 | |
| EXAMINER'S NAME
(TYPE OR PRINT) DR. JOHN S. ROGERS | | | | ADDRESS
1919 Seminary Rd.; Silver Sp. Md | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | | | 23b. DATE
12-6-1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Hebrew Friendship | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME
Danzansky-Goldberg Chapels; 1170 Rockville Pike | | | | ADDRESS
Rockville, Md. | | | | 25. DATE REC'D. BY REGISTRAR
Dec 4/1984 | | | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Rodell | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STON-RISE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

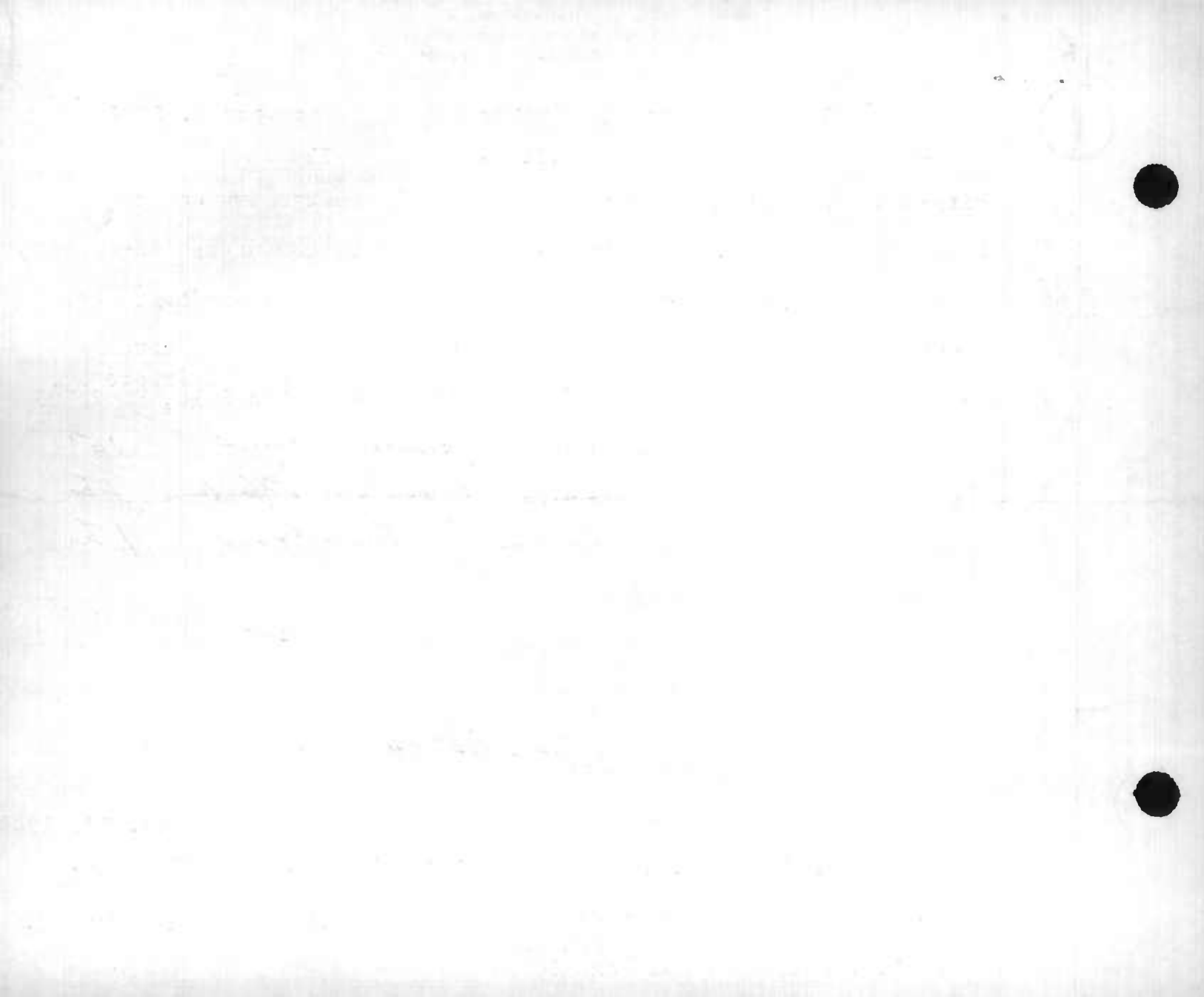
3 4 1 8 8

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | |
|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Dee Witt Abram Sperau | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 9, 1984 | | 2b. HOUR
6:55P M |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb. 10, 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | 7b. CITIZEN OF WHAT COUNTRY?
United States | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Service Manager | | 12b. KIND OF BUSINESS OR INDUSTRY
Automobile |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Bethesda | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Abram Sperau | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Nannie Beard | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
578-07-2940 | | 17. INFORMANT
ADDRESS
DeeWitt Sperau 13005 Blairmore St.
Beltsville, MD 20705 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio - Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Thrombosis | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 hr
1 hr
1 hr |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/9/84 to 12/9/84, that (I) (we) lost
saw the deceased alive on 12/31/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Stephen N. Jones, M.D. | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
Dec. 10, 1984 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS
809 Viers Mill Rd. Rockville, Md 20851 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
Dec. 12, 1984 | 23c. NAME OF CEMETERY OR CREMATORY
Rosedale Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Martinsburg, West Virginia | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland 20814 | | 25a. DATE REC'D. BY REGISTRAR
DEC 13 1984 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

BP



FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

34189
REG. NO.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
THEODORE F. SPIVEY | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-8-84 | | 2b. HOUR
145A M | |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
8-31-78 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
NORTH CAROLINA | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK OR MOST OF WORKING LIFE)
Butcher | | 12b. KIND OF BUSINESS OR INDUSTRY
Hotel |
| 13a. USUAL RESIDENCE (IF NUMBER, HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13a. COUNTY Frederick 13c. CITY OR TOWN Monrovia | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
4716 Lynnburke Rd. / 21770 | |
| 14. FATHER'S NAME
FIRST Charles MIDDLE --- LAST Spivey | | 15. MOTHER'S MAIDEN NAME
FIRST Virginia MIDDLE E. LAST Savage | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
579-14-7585 | | 17. INFORMANT
ADDRESS
Robert Young, Same address as #13. | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebrovascular Accident

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

One wk

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

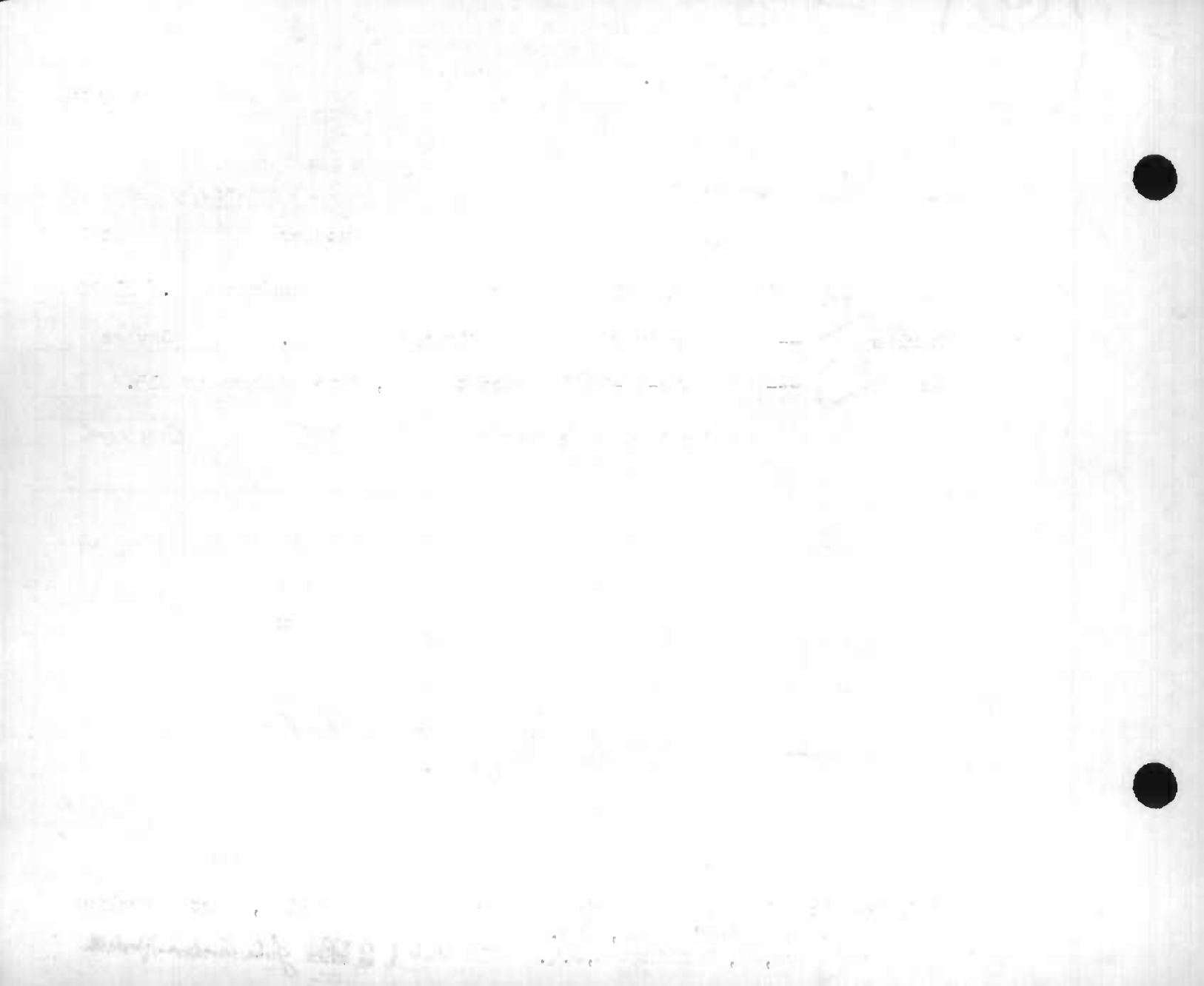
DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 19c. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 19d. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21a. INJURY OCCURRED
WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/>
AT HOME AT WORK | | 21b. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21c. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 12/3 84 to 12/7 84 , that (1) (we) lost
saw the deceased alive on 12/7 84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (1) (we) (did) (did not) give the body after death. | | | | | | | |
| 22b. SIGNATURE
Myron L. Lenkin MD | | | | DEGREE
MD | | 22c. DATE SIGNED
12/8/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MYRON L. LENKIN MD | | | | 22e. ADDRESS
2309 SHOREFIELD RD
WHEATON, MD | | | |

| | | | |
|---|------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial/Transit | 23b. DATE
12/10/84 | 23c. NAME OF CEMETERY OR CREMATORY
Spivey Square | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Leggitts, North Carolina |
| 24. FUNERAL DIRECTOR
NAME Joseph Gawler's Sons, Inc.
ADDRESS 5130 Wisconsin Ave, NW, Washington, D.C. 20016 | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
DEC 12 1984 Julia Tucker-Roberts |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 34190 | |
|--|--|--|--|---|--|--|--|---|---------------------|--------------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
EDNA P. STANTON | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12-28-84 | | | | 2b. HOUR
9:57a M | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
10-02-94 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS
90 YRS. | | 7. UNDER 1 YEAR
MONTHS DAYS | | 8. UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Chevy Chase R&N Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Administrator | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Govt. Fed. Aviation Adm. | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1316 Fenwick Lane 20910 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Unknown | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Unknown SWASON | | | | 16. ADDRESS
2700 Virginia Ave NW Wash. D.C. 20037 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Richard J. Stanton, Son | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA OF THE OVARY
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 YRS. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 75 to DEC 28 19 84, that (I) (we) last saw the deceased alive on DEC 2 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Edward A. Beeman MD | | | | 22c. DATE SIGNED
DEC 28, 1984 | | | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
EDWARD A. BEEMAN | | | | 22f. ADDRESS
8830 CAMERON ST SILVER SPRING MD. 20910 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
CREMATION | | 23b. DATE
Dec 29, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Chambers Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Riverdale PG Cty Maryland | | | | | |
| 24. FUNERAL DIRECTOR
W. W. Chambers Co 8655 Georgia Ave. SS Md 20910 | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
John Davidson | | | | | |

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STANTON



Shirley, Montgomery and Spring

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No. 1000
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BP _____

DHMH - 16 50M 4/83

(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|---|
| FOR
1 - STATE REGISTRAR | | | | | REG. NO. 34191 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
REBA STEIN | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR
DECEMBER 5, 1984 6:45P M | | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
APRIL 12, 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
RUSSIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
ROCKVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ROCKVILLE NURSING HOME | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MERCHANT | | 12b. KIND OF BUSINESS OR INDUSTRY
TAILOR | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE COUNTRY 13b. CITY OR TOWN 13c. INSIDE CITY LIMITS?
MARYLAND MONTGOMERY SILVER SPRING YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13d. STREET ADDRESS / ZIP CODE
2123 COLERIDGE DRIVE ----20910---- | | | | |
| 14. FATHER'S NAME FIRST MIDDLE
REVIN COHEN | | | | 15. MOTHER'S MAIDEN NAME MIDDLE
FANNIE (UNASCERTAINABLE) | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
577-84-1334 | | 17. INFORMANT ADDRESS
BERNICE S. GOLDBERG, 2123 COLERIDGE DRIVE, SILVER SPRING, MD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 wk
years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
<u>Carcinoma of Lsp</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)
21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> 19 <u>83</u> , to <u>Dec</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>12/14</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>DR. RAYMOND T. BENACK, M. D.</u> | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
<u>12/5/84</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. RAYMOND T. BENACK, M. D. | | | | | 22e. ADDRESS
4115 COLIE DRIVE
WHEATON, MARYLAND 20906 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
12/7/1984 | | 23c. NAME OF BURYING PLACE
BNAT ISRAEL CONGREGATION CEMETERY | | | 23d. LOCATION
CITY OR TOWN COUNTY
OXON HILL, PR. GEO., MD. | | |
| 24. FUNERAL DIRECTOR
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME
232 CARROLL STREET, N. W., WASHINGTON, D. C. | | | | | | | | | |
| 25. REGISTRAR'S SIGNATURE
<u>John Davidson Rodella</u> | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 34192 | | | |
|---|--|-----------------------|--|--|--|--|-------|
| 1. FOR Film G604 item 15
STATE 6/10/85 rja
REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
First MIDDLE LAST
Jordan Stepper | | | | 2a. DATE OF DEATH MONTH DAY YEAR
December 16, 1984 | | | |
| 3. SEX
Male | | | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
Dec. 10 1914 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Austria | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Samuel Stepper | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Zazella Gislea (unknown) | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII | | 17. INFORMANT ADDRESS
1905 Tree Top Lane
Shirley B. Altschuler-dau-Sil. Spr. Md. 20904 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiac arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>coronary atherosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 hours | | | | | | | years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a)
<u>hypoxic encephalopathy</u> | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/16</u> 19 <u>84</u> to <u>12/16</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>12/16</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Mark Rosen</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/17/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Mark Rosen | | | | 22e. ADDRESS
Silver Spring, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12-18-84 | | 23c. NAME OF CEMETERY OR CREMATORY
Judean Gardens | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Olney Montgomery Md. | |
| 24. FUNERAL DIRECTOR
Hines/Rinaldi Funeral Home | | | | 11800 N.H. Ave.,
S.S. Md. 20904 | | 25a. DATE RECEIVED BY REGISTRAR
DEC 21 1984 | |



2026 CC

WHITE

REPORT OF INVESTIGATION

U.S. DEPT. OF JUSTICE

DATE OF REPORT

BY

AND

AT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

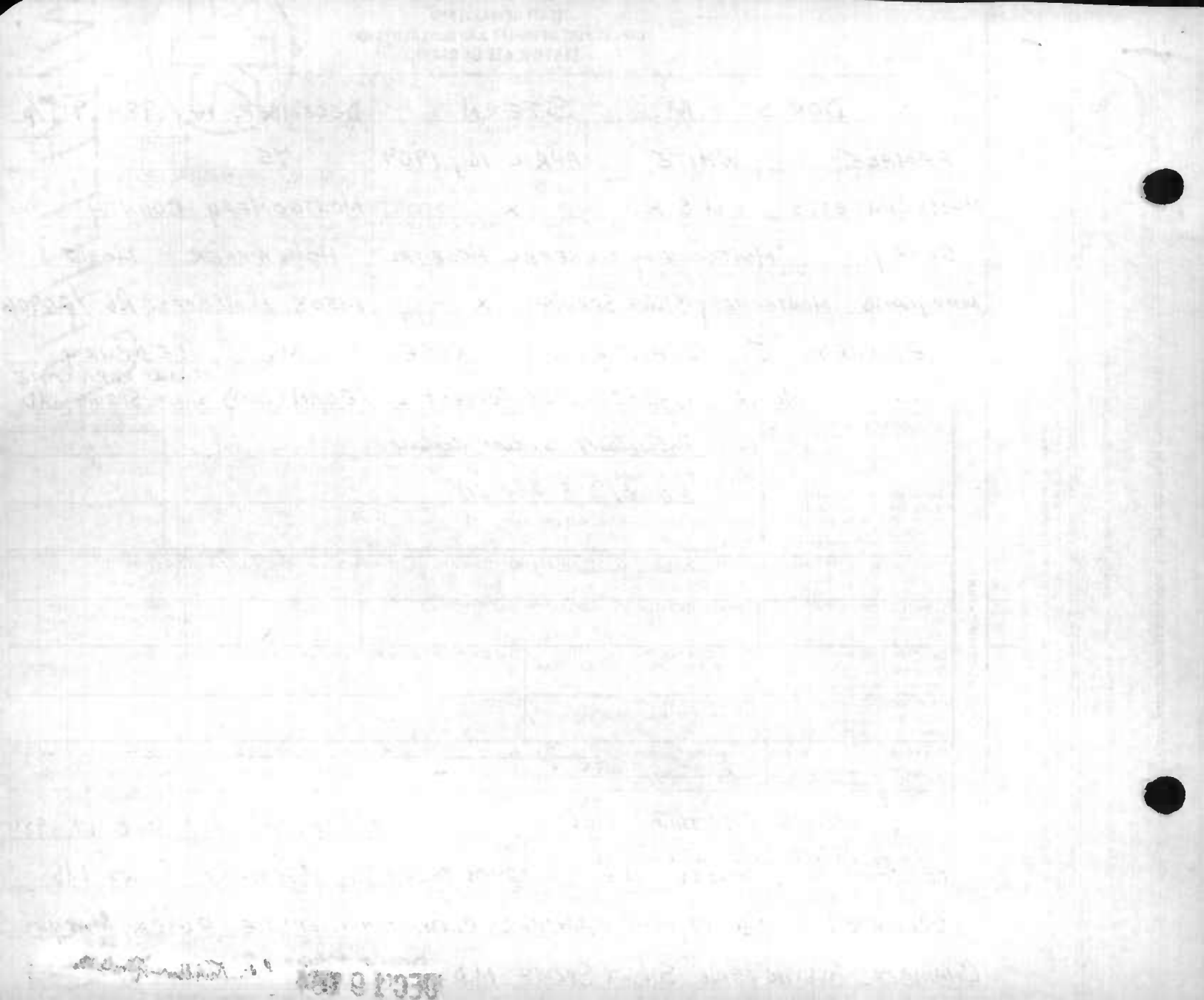
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 4 1 9 3

1- FOR
STATE
REGISTRAR

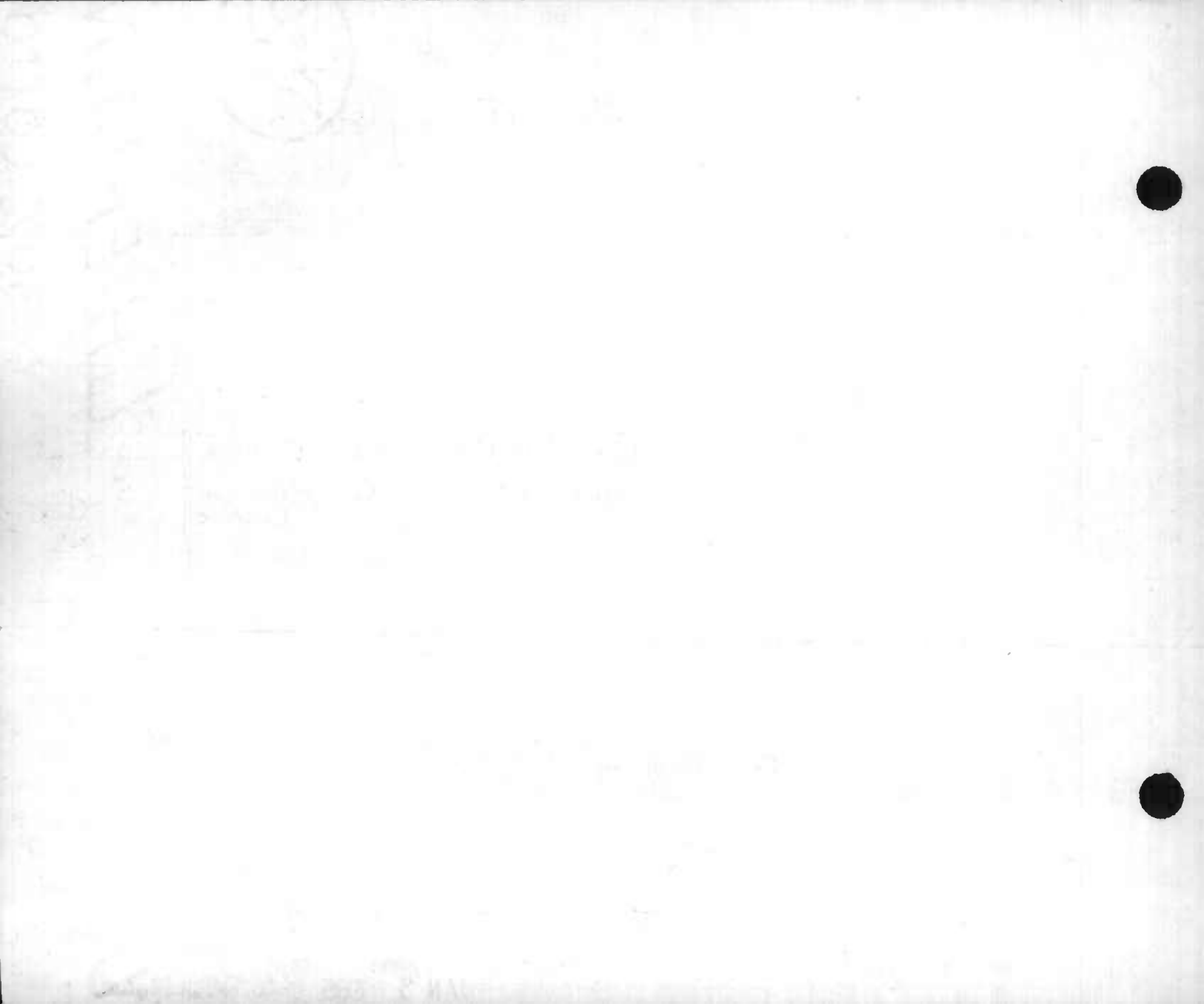
REG. NO.

| | | | | | | | | | |
|---|--|---|---|---|---|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
DORIS M. STERN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 16, 1984 | | | 2b. HOUR
9:00 p.m. | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
APRIL 16, 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MASSACHUSETTS | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
OLNEY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MONTGOMERY GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY
HOME | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
EDWARD J. GRANFIELD | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ROSE M. LEDBURY | | | 16. STREET ADDRESS
14508 HONECREST RD. / 20906 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
045-22-2928 | | 17. INFORMANT
ADDRESS
FORREST L. REGAN (SON) 13212 KARA LANE SILVER SPRING, MD. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intractable Cardiac failure
DUE TO, OR AS A CONSEQUENCE OF
(b) NASCVD & old MI
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 yr.
10 yrs. | | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan , 19 83 , to Dec. 16 , 19 84 , that (I) (we) lost
saw the deceased alive on Dec. 16 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Frederick Mooman, M.D. | | | | | 22c. DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22d. DATE SIGNED
DEC. 17, 1984 | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
Frederick Mooman, M.D. | | | | | 22f. ADDRESS
2901 OLNEY-SANDY SPRING RD. OLNEY, MD. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | | | 23b. DATE
DEC. 17, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
CHAMBERS CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
RIVERDALE, P.G. CO., MARYLAND | | |
| 24. FUNERAL DIRECTOR
NAME
CHAMBERS FUNERAL HOME SILVER SPRING, MD. | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 18 1984 | | | | |
| 25b. REGISTRAR'S SIGNATURE
John H. ... | | | | | | | | | |



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

| | | | | | | | | | | | |
|---|--|--|---|---|--|---|--|---|--|--|--|
| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 34194 | |
| FOR
1- STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ROGER Stewart | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Dec. 19, 1984 | | | 2b. HOUR
10:40 PM | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
June 20, 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY)
87 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired- Wash. | | | 12b. KIND OF BUSINESS OR INDUSTRY
Capt. Main. | | |
| 13a. STATE
Washington, DC. | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
5027 57th Ave, N.E. 99999 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Stewart | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Louise Murphy | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
220 09 319 | | | 17. INFORMANT
ADDRESS
Diane Reid-daughter-5027 57th Ave | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular Accident
DUE TO, OR AS A CONSEQUENCE OF (b) Arterio sclerotic Cerebrovascular Disease
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days
5 years | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from September 19, 83, to December 19, 84, that (I) (we) lost saw the deceased alive on December 19, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
John F. Gustafson M.D. | | | | | | DEGREE
M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
December 20, 1984 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John F. Gustafson, M.D. | | | | | | 22e. ADDRESS
5480 Wisconsin Avenue Chevy Chase Md. 20815 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | | | 23b. DATE
Dec. 19, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Brookgrove Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Laytonville, Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Stewart Funeral Home-4001 Benning Road, NE. | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |



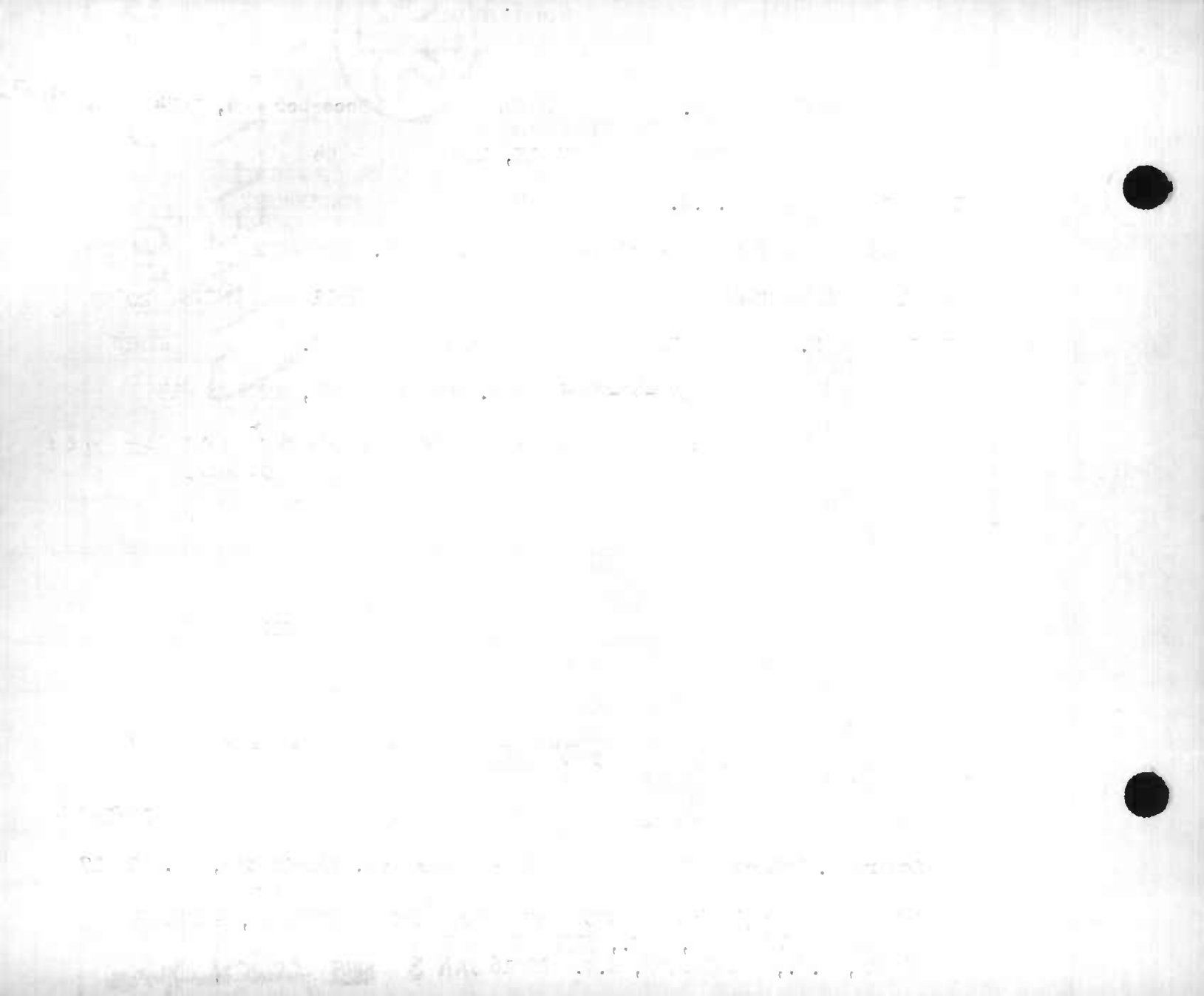
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. 34195 | | | | |
|--|--|--|--|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME FIRST MARY MIDDLE P. LAST STONE | | | | | 2a. DATE OF DEATH MONTH DAY YEAR December 24, 1984 | | | | |
| 3. SEX FEMALE | | | | | 4. RACE WHITE | | | | |
| 5. DATE OF BIRTH MONTH DAY YEAR MAY 15, 1890 | | | | | 6. AGE (IN YEARS LAST BIRTHDAY) 94 | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MISSOURI | | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | | |
| 10. CITY OR TOWN OF DEATH CHEVY CHASE | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BETHESDA RETIREMENT & NURSING CTR. | | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | | | | | 12b. KIND OF BUSINESS OR INDUSTRY OWN HOME | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE MARYLAND | | | | | 13b. COUNTY MONTGOMERY | | | | |
| 13c. CITY OR TOWN KENSINGTON | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 13e. STREET ADDRESS / ZIP CODE 3311 WAKE DRIVE 20895 | | | | | | | | | |
| 14. FATHER'S NAME FIRST SIMON MIDDLE B. LAST PHIFER | | | | | 15. MOTHER'S MAIDEN NAME FIRST BELLE MIDDLE V. LAST HINES | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | | 16b. SOCIAL SECURITY NO. 579-40-7025 | | | | |
| 17. INFORMANT ADDRESS MRS. RUTH BURCHARD, SAME AS #13 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CEREBROVASCULAR DISEASE | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 YRS | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | |
| | | | | | DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from about 1970 to 12/24/84, that (I) (we) lost saw the deceased alive on 12/24/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Richard H. Pollen MD | | | | | 22c. DATE SIGNED 12/24/84 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard H. Pollen MD | | | | | 22e. ADDRESS 10400 Conn Ave. Kensington, Md. 20817 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | | 23b. DATE 12/27/84 | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND, MARYLAND | | | | |
| 24. FUNERAL HOME JOSEPH GAWLER'S SONS, INC., 5130 WISCONSIN AVENUE, N.W., WASHINGTON, D.C. 20016 | | | | | 25a. DATE REC'D. BY REGISTRAR 3 JAN 1985 | | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 7 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 34196
REG. NO. | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) JAMES D. STUBBINGS | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12-23-84 | | | | 2b. HOUR
7:45 a.m. | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
September 3, 1889 | | 6. AGE (IN YEARS LAST BIRTHDAY)
95 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
England | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Security Guard | | 12b. KIND OF BUSINESS OR INDUSTRY
College | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
6411 Earlham Drive 20817 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James Woolmer Stubbings | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Vivas Jane Simms | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No N/A | | | | 16b. SOCIAL SECURITY NO.
577-26-5301A | | 17. INFORMANT (Daughter) ADDRESS
Vivas M. Allen, Bethesda, Maryland 20817 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory failure
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Pulmonary edema
DUE TO, OR AS A CONSEQUENCE OF
(c) Atherosclerotic heart disease | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Hours 6 days
Years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Calcific Aortic Stenosis | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from December 17, 1984 to Dec 23, 1984 , that (I) (we) last saw the deceased alive on Dec 23, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Joseph A. Romeo MD | | | | | | DEGREE
MD | | 22c. DATE SIGNED
12/23/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Joseph A. Romeo MD | | | | | | 22e. ADDRESS
10401 Old Georgetown Rd. Bethesda, Md. 20814 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
December 27, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring, Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 24 1984 | | 25b. REGISTRAR'S SIGNATURE
John L. ... | |

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

34197

| | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Frederick R. Sullivan | | | 2a. DATE OF DEATH
MONTH DAY YEAR
11 27 84 | | | 2b. HOUR
6 ⁵⁵ PM | | | | |
| 3. SEX
M Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
1 04 22 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington DC | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
X MD Montgomery MD | | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Painter | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Business | | |
| 13a. STATE
Maryland | | | 13b. CITY OR TOWN
Suitland | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS
4721 Homer Avenue 20746 | | | |
| 14. FATHER'S NAME
Frederick R. Sullivan | | | 15. MOTHER'S MAIDEN NAME
Mary Brown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
WWII 577-22-5218 | | 17. INFORMANT
Clara M. Sullivan | | | 17. ADDRESS
Same as #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>respiratory failure</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause, (a), stating the underlying cause last:
(b) <u>phlebotomy</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>myocardial infarction</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):
<u>coronary artery disease, old myocardial infarction</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/5</u> , 19 <u>84</u> , to <u>11/27</u> , 19 <u>84</u> , that (I) (we) lost <u>see above</u> (he) (she) (it) (did not view the body after death). | | | | | | | | | | |
| 22b. SIGNATURE
<u>Lewis H. Dennis</u> | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>11/28/84</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Lewis H. Dennis, M.D. | | | 22e. ADDRESS
831 University Blvd East Sil. Spg., Md | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
12-3-84 | | 23c. NAME OF CEMETERY OR CREMATORY
Maryland Vet. Cem | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Cheltenham PG Md | | | |
| 24. FUNERAL DIRECTOR
NAME
Robert E. Wilhelm Funeral Home | | | ADDRESS
Suitland, Md. | | 25a. DATE REC'D. BY REGISTRAR
DEC 05 1984 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson</u> | | | |

BP



[Faint, illegible handwriting and bleed-through from the reverse side of the page.]

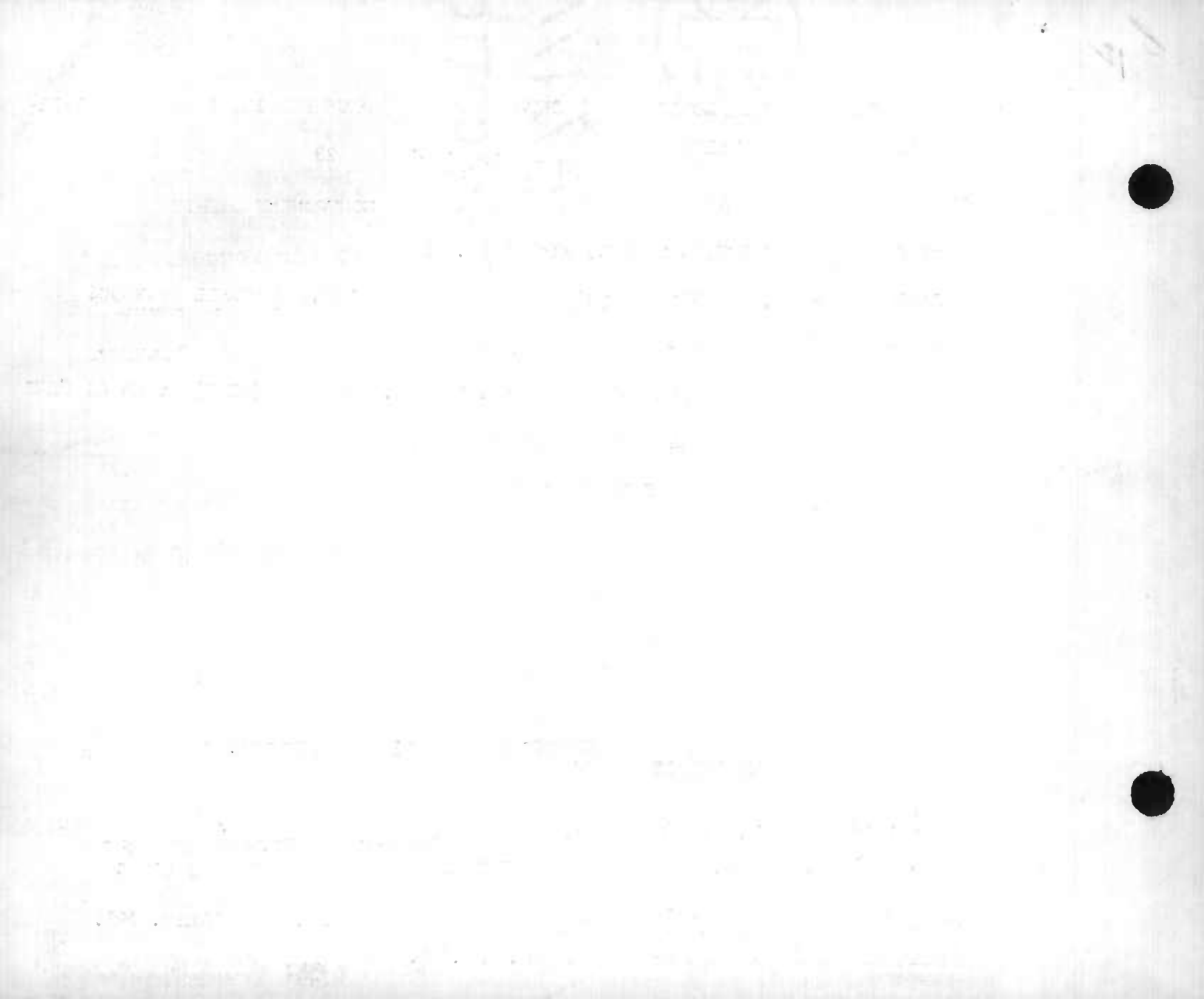
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

34198

FOR
1- STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|---|---|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
CRAIG LOUIS SUTO | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 12, 1984 | | 2b. HOUR
12:32 P _M | | | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
JUNE 10, 1961 | | 6. AGE (IN YEARS LAST BIRTHDAY)
23 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ohio | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
CLINICAL CENTER, NIH, BETH. MD | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
US Air Force | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE COUNTY
MARYLAND PG | | | | 13b. CITY OR TOWN
Beltsville | | 13c. STREET ADDRESS / ZIP CODE
11429 Cherry Hill Road 20705 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Louis Suto | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Barbara Pearson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes | | | | 16b. SOCIAL SECURITY NO.
271-44-7803 | | 17. INFORMANT
ADDRESS
MRS. MARY A. SUTO (WIFE) SAME AS 13E | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) EWINGS SARCOMA
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| MEDICAL CERTIFICATION | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>OCTOBER 9</u> , 19 <u>81</u> , to <u>DECEMBER 12</u> , <u>84</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>DECEMBER 12</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Carolyn A. Felix M.D.
Carolyn A. Felix M.D. | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
12/12/84 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS
NATIONAL INSTITUTES OF HEALTH
CLINICAL CENTER, BETHESDA, MD 20205 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
12/15/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
S.S. Mont. Md. | | | |
| 24. FUNERAL DIRECTOR
Hines/Rinaldi 11800 New Hamp Ave. S.S. Md. | | | | | | 25a. DATE REC'D BY REGISTRAR
DEC 13 1984 | | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson Rinaldi | | |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

34199

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|---|---|---|---|--|--|--|
| 1. DECEASED NAME <u>WILLIAM ESTEL SWEAT</u> | | | 2a. DATE OF DEATH MONTH <u>Dec</u> DAY <u>16</u> YEAR <u>1984</u> | | | 2b. HOUR <u>12 Noon</u> | | | |
| 3 SEX <u>male</u> | | 4 RACE <u>Cauc</u> | | 5 DATE OF BIRTH MONTH <u>5</u> DAY <u>29</u> YEAR <u>1905</u> | | 6 AGE (IN YEARS LAST BIRTHDAY) <u>79</u> YRS. | | IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u> IF UNDER 24 HRS HOURS <u></u> MIN <u></u> | |
| 7a. BIRTHPLACE STATE OR FOREIGN <u>INDIANA</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD. | | | |
| 10 CITY OR TOWN OF DEATH <u>Baithersburg</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>19223 Wheelwright Dr</u> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Carpenter</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u> | |
| 13a. STATE <u>Maryland</u> | | | 13b. COUNTY <u>Mont.</u> | | 13c. CITY OR TOWN <u>Baithersburg</u> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14 FATHER'S NAME FIRST <u>Martin</u> MIDDLE <u>S.</u> LAST <u>Sweat</u> | | | 15 MOTHER'S MAIDEN NAME FIRST <u>Cordelia</u> MIDDLE <u>Stiles</u> LAST <u></u> | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u> | | | |
| 16b. SOCIAL SECURITY NO. <u>305-18-3683</u> | | | 17 INFORMANT <u>Eliz Seatter</u> | | | ADDRESS <u>20612 Cleaning Ct, Gaithersburg, Md.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cancer of the Lung</u>
DUE TO OR AS A CONSEQUENCE OF (b) <u>Squamous cell</u> with
DUE TO OR AS A CONSEQUENCE OF (c) <u>Cerebral Metastasis</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION <u>Sept, 1984</u> | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Biopsy of Lung Mass</u> | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u> | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 26</u> 19 <u>84</u> to <u>Dec 16</u> 19 <u>84</u> , that (I) (we) saw the deceased alive on <u>Nov 26</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Co Stuart Scott MD</u> | | | DEGREE <u>MD</u> | | | 22c. DATE SIGNED <u>Dec. 16, 1984</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>G. Stuart Scott MD</u> | | | 22e. ADDRESS <u>19201 Mont. Vill. Ave, Gaithersburg Md</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>CREMATION</u> | | | 23b. DATE <u>DEC. 17, 1984</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Balt./Wash. Crom.</u> | | 23d. LOCATION CITY OR TOWN <u>Laurel</u> COUNTY <u>P. George</u> STATE <u>Md.</u> | | |
| 24 FUNERAL DIRECTOR NAME <u>FRANCIS H. BARBER FUNERAL HOME</u> | | | ADDRESS <u>LAYTONSVILLE, MD. 20879</u> | | DATE REC'D. BY REGISTRAR <u>DEC 19 1984</u> | | 25b. REGISTRAR'S SIGNATURE <u>John Barber</u> | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 4 2 0 0
REG. NO.

| | | | | | | | |
|---|--|---|--|---|------------------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ENID MAE TANTALO | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 24 1984 | | 2b. HOUR
MIN.
12:15 a | | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
MAY 10 1930 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
54 | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NORTH CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
At Home | |
| 13a. STATE
SOUTH CAROLINA | | 13b. COUNTY
HORRY | | 13c. CITY OR TOWN
MYRTLE BEACH | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
FRED MONROE NORRIS | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
NANCY LOUISE MORRIS | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
242-36-4128 | |
| 17. INFORMANT
ADDRESS
LOUIS TANTALO, ROUTE 5, BOX 517, MYRTLE BEACH | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SC 29577
SMALL CELL CARCINOMA OF THE LUNG
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
_____ | | SC 29577 | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | |
| 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 2, 1984 to DECEMBER 24, 1984 that (I) (we) last saw the deceased alive on DECEMBER 24, 1984 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
R. L. NEMEC | |
| 22c. DATE SIGNED
7 Dec 84 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
R. L. NEMEC, LT, MC, USNR | | 22e. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND,
NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | | 22f. DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
Dec. 27, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Chambers Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Riverdale, P.G. Cty., Maryland | |
| 24. FUNERAL DIRECTOR
NAME
W.W. CHAMBERS CO., 8655 Ga. Ave., S.S. Md. 20910 | | 25a. DATE REC'D. BY REGISTRAR
DEC 31 1984 | | 25b. REGISTRAR'S SIGNATURE
J. H. Burden | | 25c. REGISTRAR'S NAME
J. H. Burden | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 4 2 0 1
REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|------------------|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
James E. Tappin | | | | 2a. DATE KNOWN OF DEATH
XX MONTH DAY YEAR
12-23 1984 | | | | 2b. HOUR
M
7:18 P
M | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 21 1912 | | 6. AGE (IN YEARS)
LAST BIRTHDAY YRS.
72 | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
12-23 1984 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Guyana, S. A. | | | | 7b. CITIZEN OF WHAT COUNTRY?
Guyana | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | |
| 10. CITY OR TOWN OF DEATH
Onley | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery County Gen'l. Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Security Guard | |
| 13a. STATE
Md. | | | | 13b. CITY OR TOWN
Montgomery | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS
14227 Grand Pr Rd. 209-20906 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Tappin | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Theresa Tappin | | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | |
| 17. INFORMANT
Longbrach, Calif.
Ernest Tappin 436 Bellflower Blvd. | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple Injuries
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOURS MIN MONTH DAY YEAR
6:35 P.M. 12-23 1984 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
pedestrian struck by auto | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
road | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Conn. Ave. & Grand Pre Rd., Silver Spring, Montgomery Co., Md. | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | |
| ACTUAL SIGNATURE
Dennis F. Smyth, M.D. | | | | TITLE (SPECIFY)
Assistant MEDICAL EXAMINER | | | | DATE SIGNED
12-24-84 | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Dennis F. Smyth, M.D. | | | | ADDRESS
111 Penn St., Balto., Md. 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
1-2-85 | | 23c. NAME OF CEMETERY OR CREMATORY
GATES of Heaven | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring Md. | |
| 24. FUNERAL DIRECTOR
NAME
Jas. A. MORTON & Sons | | | | ADDRESS
1701 Laurens | | 25a. DATE REC'D. BY REGISTRAR
JAN 2 1985 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201. BALTIMORE, MARYLAND - 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

2000

1/15/2000

1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26



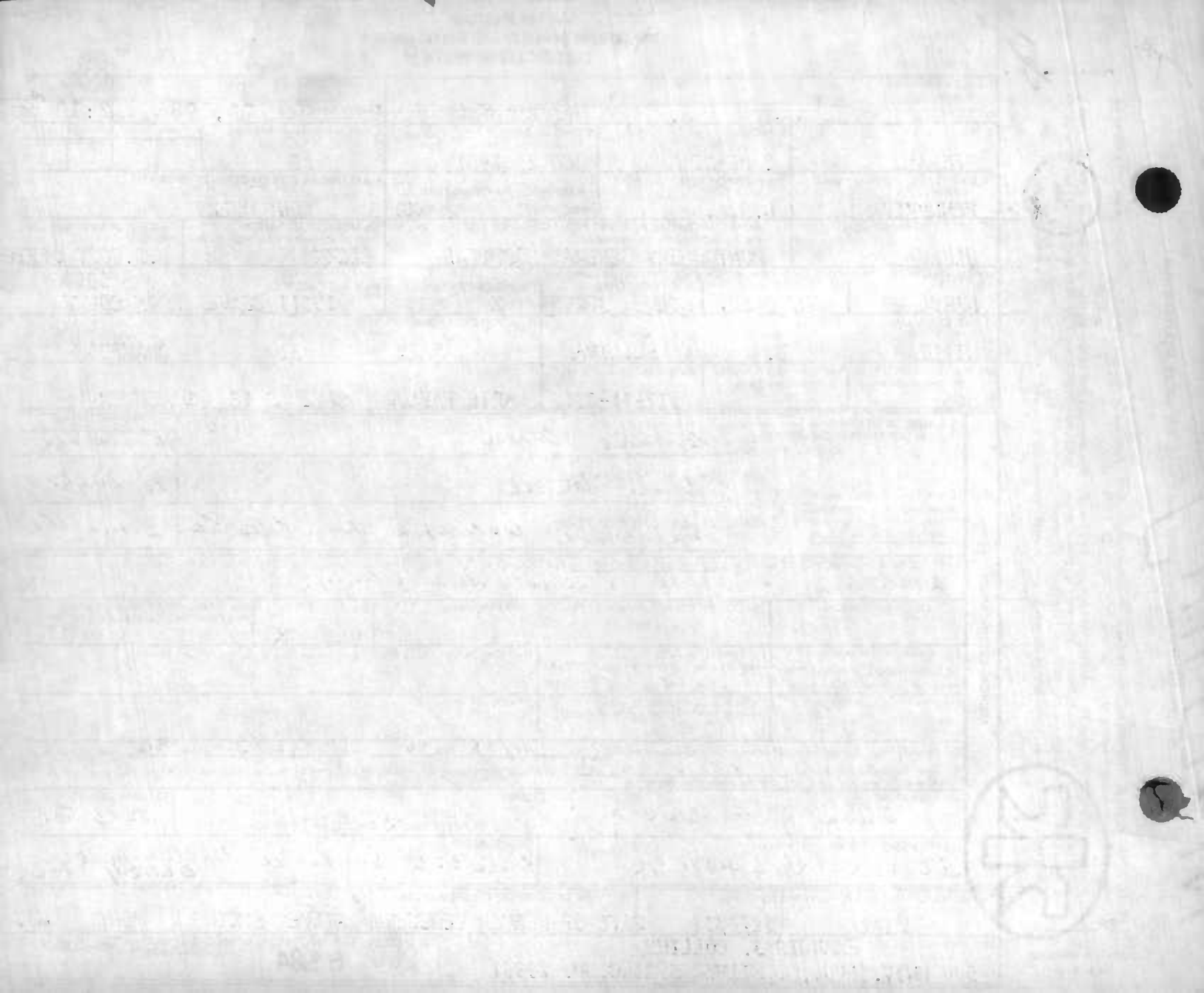
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 4 2 0 2
REG. NO.

| | | | | | |
|---|--|--|---|-------------------------------|-----|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Eleanor A. Tarczynski | | December 03, 1984 | | 2:10 pm | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| FEMALE | CAUCASIAN | AUG 25, 1901 | 83 YRS. | IF UNDER 24 HRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| PENNSYLVANIA | U.S.A. | WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| OLNEY | MONTGOMERY GENERAL HOSPITAL | CLERK | U.S. POST OFFICE | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| MARYLAND | MONTGOMERY | SILVER SPRING | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20906 15311 BEAVERBROOK COURT | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | |
| WILLIAM B. SULLIVAN | MARY J. CHAMPION | 17. INFORMANT ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE (a) Cordiac Arrest | | Immediate | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Renal Failure | | 10 days. | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) metastatic carcinoma from Colon Ca. | | 2 months | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| Diabetes, Peripheral Vascular Insufficiency. | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | HOUR A.M. MONTH DAY YEAR | | | | |
| | P.M. 19 | | | | |
| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from | 22c. DATE SIGNED | | | | |
| saw the deceased alive on 12-2-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | 12-3-84. | | | | |
| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| OLIVER J. LAWLESS MD | | | | 12-3-84. | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS | | | | |
| OLIVER J. LAWLESS | Suite 323 18111 Prince Philip Drive MD. | | OLNEY | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION | 23e. STATE | |
| BURIAL | 12/6/84 | GATE OF HEAVEN CEMETERY | SILVER SPRING | MONT | MD. |
| 24. FUNERAL DIRECTOR | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| FRANCIS J. COLLINS | DEC 6 1984 | | John Davidson-Randall | | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. These permits are carbon copies. Pages 1 and 2 should be filed with the 24-hour death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MDHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 4 2 0 3
REG. NO.

| | | | | | | | | | | | | | | |
|--|--------|---|-------------------------------------|---|------------------------------|--|--------------------------------------|--|---------------------------|--|--|--|--|-----------------------------------|
| FOR
STATE
REGISTRAR | | FIRST | | MIDDLE | | LAST | | 2a DATE KNOWN OF DEATH ESTI- MATED | | MONTH DAY YEAR | | 2b HOUR | | |
| DECEASED NAME
(TYPE OR PRINT) | | Makopoi | | C. | | Tau | | 12-22 | | 1984 | | 9:00 P.M. | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH
MONTH DAY YEAR | 6 AGE (IN YEARS)
(LAST BIRTHDAY) | 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
| Female | Black | August 3, 1963 | 21 YRS. | Lesotho | Lesotho | | Montgomery County, MD | | Bethesda | Suburban Hospital | Student | N/A | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | |
| Maryland | | Montgomery | | Bethesda | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 7013 Loch Lomond Dr./ 20817 | | Maama | | Tau Malineo Cebekulu | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Drowning</u>
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last
<u>9104</u>
(b)
(c)
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | |
| No | | N/A | | Mr. Ntahli Matete, Counsellor, Embassy Lesotho, 1601 Conn., Ave., N.W. | | | | | | 19c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR <u>8:00</u> P.M. MONTH <u>12</u> DAY <u>22</u> YEAR <u>1984</u> | | 21c. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
<u>Home</u> | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. LOCATION
STREET CITY OR TOWN COUNTY STATE
<u>7013 Loom Lomand Dr., Bethesda, Mont. Co., Md.</u> | | 22a. I certify that I took charge of the removal described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| Dennis F. Smyth, M.D. | | Assistant | | 12-24-84 | | Burial | | January 5, 1985 | | Tau Family Cemetery | | Petseng, Lesotho | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | 24 FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | 26. P.A., Bethesda, Maryland U.S.A. | | JAN 2 1985 Julia Davidson-Randall | | |
| 111 Penn St., Balto., Md. 21201 | | | | Robert A. Pumphrey Funeral Homes, ADDRESS | | | | | | | | | | |

DEB

NOT TO BE

OWD

MAV



Pauline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. A copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

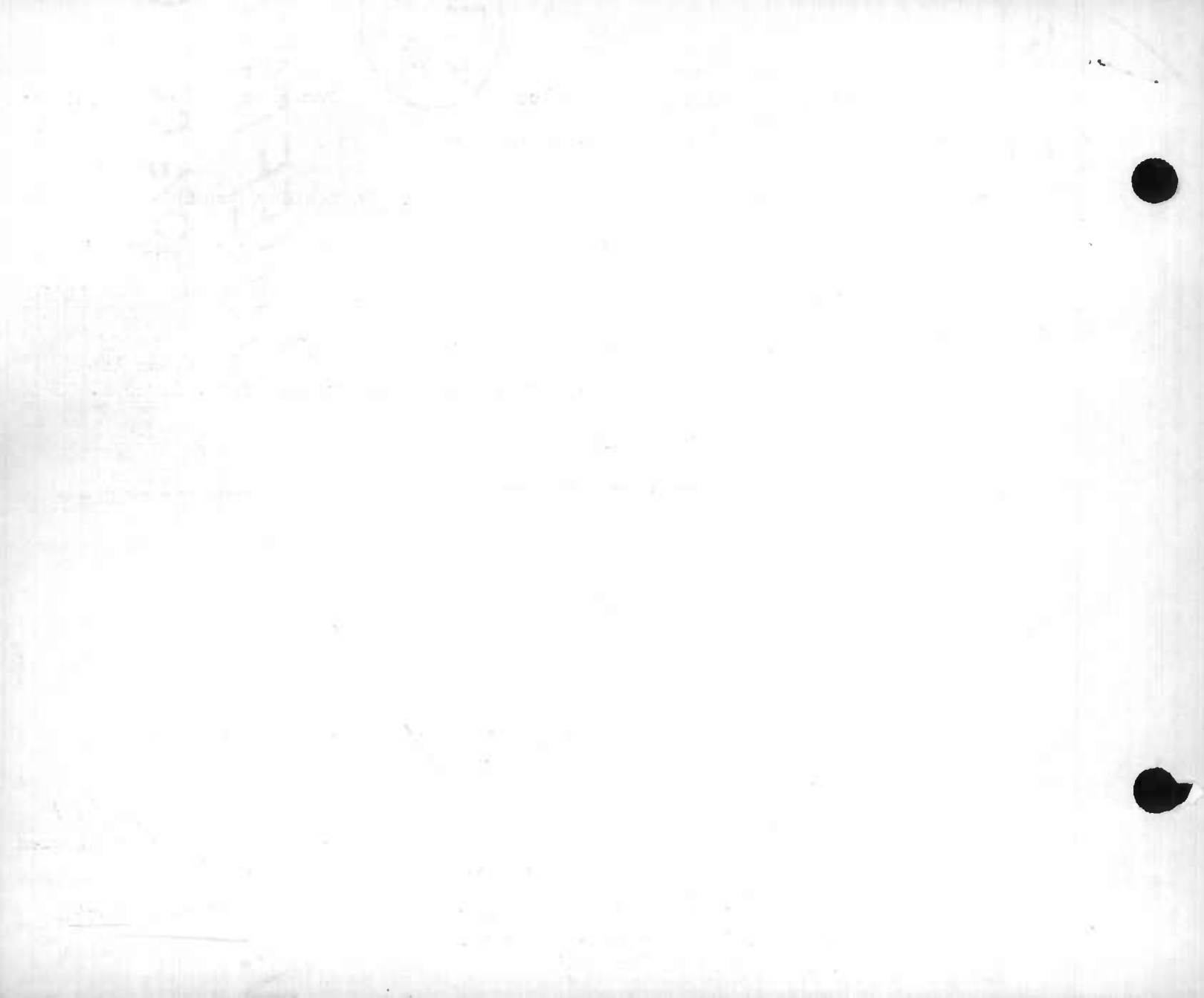
| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH 84 | | | | | | | | | | 34204
REG. NO. | |
|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) AMY L. TAVELLA | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR HOUR
12 12 84 9:40 AM | | | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 02 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
England | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD | | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
Maryland Montgomery Rockville | | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
90 Monroe Street #303 20850 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Albert Edgar Kemp | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Harriett Jane Staines | | | | ADDRESS
205 Curry Ford Lane | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
138 28 8023 | | 17. INFORMANT
Doris M. Gunsten Gaithersburg, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Minutes | |
| DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | (b) Chronic Congestive Heart Failure 2 years | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) OLD MYOCARDIAL INFARCT | | | | | | | | | | 4 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: no | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
8/15 84 12/12 84 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
(STREET CITY OR TOWN COUNTY STATE)
50 W. Edmonston Dr Rockville, Md | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from 8/15 84 to 12/12 84 and that (2) (my/our) opinion of death occurred on the date and hour and from the causes stated above; (3) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Barton J. Gersten | | | | DEGREE
M.D. | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/12/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BARTON J. GERSTEN | | | | 22e. ADDRESS
50 W. Edmonston Dr Rockville, Md | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | 23b. DATE
Dec. 17, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Westlawn Mem. Gardens Ft. Lauderdale, Florida | | 23d. LOCATION
(CITY OR TOWN COUNTY STATE) | | | | | |
| 24. FUNERAL DIRECTOR
NAME
ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 18 1984 | | 25b. REGISTRAR'S SIGNATURE
Davidson | | | |

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be examined by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 34205
REG. NO. | | | |
|---|--|--|--|--|--------------------------|--|--|---|--|---|--|-----------------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR | | | |
| Hubert Neet Taylor | | | | | December 1, 1984 | | | | | 5:25 A.M. | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | 7. IF UNDER 24 HRS. | | | |
| Male | | White | | Sept. 28, 1911 | | 73 | | MONTHS | | DAYS | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Indiana | | United States | | | | Montgomery County MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Bethesda | | NIH, The Clinical Center | | | | | | | | Metal Temporer | | Automobile | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | 99999 | | | |
| Florida | | St. Lucie | | Ft. Pierce | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | R.R. 4, Box 188-T | | 33450 | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| Charles M. Taylor | | | | | Mary Iva Conklin | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | |
| No | | | | | 312-12-9399 | | Mrs. Mary Frushour, Sister, Ft. Pierce, FL 33450 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE (a) <u>Pneumonia</u> | | | | | | | | | | Weeks | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | Years | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | |
| (b) <u>Malignant Lymphoma</u> | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (c) _____ | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| | | | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) | | | | 21f. LOCATION | | | | | |
| WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK | | | | | | | | CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>November 25</u> , 19 <u>79</u> , to <u>December 1</u> , 19 <u>84</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>December 1</u> , 19 <u>84</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | 22c. DATE SIGNED | | | | | |
| <u>Carl E. Freter, M.D., Ph.D.</u> | | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 12/2/84 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | | | | | |
| CARL E. FRETER, M.D., Ph.D. | | | | | | Clinical Center, National Institutes of Health, Bethesda, Md. 20205 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | |
| Burial | | | | December 5, 1984 | | Hillcrest Memorial Gardens | | | | CITY OR TOWN COUNTY STATE | | | |
| | | | | | | Fort Pierce, Florida | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland | | | | | | DEC 5 1984 | | <u>Julia Seaton</u> | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 4 2 0 6

| | | | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|---|--|--|
| 1. DECEASED-NAME
(Type or print) EDITH | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year Dec 12 1984 | | | 2b. HOUR
4:50 A M | | |
| 3. SEX
Female | | | 4. RACE
White | | | 5. DATE OF BIRTH
10/10/1899 | | | 6. AGE (In years lost birthday)
85 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country)
Iowa | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Rockville Nursing Home | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
clerk | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Montgomery | | | 13c. CITY OR TOWN
Boyd | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 13e. STREET AND NUMBER
20841 | | | 13f. STREET AND NUMBER
79005 Buck Lodge Rd. | | | 13g. STREET AND NUMBER
20841 | | | 13h. STREET AND NUMBER
20841 | | |
| 14. FATHER'S NAME
First Middle Last
Matthew | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Byrne Margaret O'Brien | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) NO | | | 16b. SOCIAL SECURITY NO.
297-24-5057 | | |
| 17. INFORMANT
Address
Mrs. Byrne Boyd Md. | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Left hemiplegia
DUE TO, OR AS A CONSEQUENCE OF
(b) central vascular accident
DUE TO, OR AS A CONSEQUENCE OF
(c) arteriosclerotic Cardiovascular disease | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 days
10 days
year | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Transient ischaemic attacks | | | | | | | | | | | |
| 19a. DATE OF OPERATION
none | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/29 , 1977, to 12/12 , 1984, that (I) (we) last saw the deceased alive on 10 Dec 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
John J. Fawcett | | | 22c. DATE SIGNED
12/12/84 | | | 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | |
| 23a. BURIAL (CREMATION, REMOVAL) (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | |
| 24. FUNERAL DIRECTOR
W.C. Hillier | | | 25a. REC'D BY REGISTRAR
DEC 19 1984 | | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Rodwell | | | | | |

UNITED STATES OF AMERICA

DEPARTMENT OF HEALTH AND HUMAN SERVICES

5

DEC 19 1984
FBI - NEW YORK

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

34207

REG. NO.

| | | | | | |
|---|----------------------------|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Grace Voorhees Thompson | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 29, 1984 | | 2b. HOUR
6:00P M |
| 3 SEX
Female | 4 RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
April 17, 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Brooke Grove Nursing Home | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Gaithersburg |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Samuel Edward Voorhees | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rhoda Ellen Hart | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
678-05-1979D | | 17. INFORMANT
ADDRESS
Mr. William E. Thompson, Son, Same as item #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF:
(b) A.S.H.D.
DUE TO, OR AS A CONSEQUENCE OF:
(c) Years | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
4 days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1960 to 12-29 19 84 , that (I) (we) last saw the deceased alive on 12-28 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 27a. SIGNATURE
Jack Schumacher M.D.
DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 27b. DATE SIGNED
December 30, 1984 | |
| 27a. PHYSICIAN'S NAME (TYPE OR PRINT)
Jack Schumacher, M.D. | | 27c. ADDRESS
105 Russell Avenue
Gaithersburg, Maryland 20877 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3 January 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National Cemetery | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3 January 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National Cemetery | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington, Virginia | | 24. FUNERAL DIRECTOR
NAME ADDRESS
Robert A. Pumphrey Funeral Homes,
P.A., Rockville, Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Robert A. Pumphrey Funeral Homes,
P.A., Rockville, Maryland | | 25a. DATE REC'D. BY REGISTRAR
JAN 2 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Rendell | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10

1. The first part of the document is a list of names and addresses.

2. The second part of the document is a list of names and addresses.

3. The third part of the document is a list of names and addresses.

4. The fourth part of the document is a list of names and addresses.

5. The fifth part of the document is a list of names and addresses.

6. The sixth part of the document is a list of names and addresses.

7. The seventh part of the document is a list of names and addresses.

8. The eighth part of the document is a list of names and addresses.

9. The ninth part of the document is a list of names and addresses.

10. The tenth part of the document is a list of names and addresses.

11. The eleventh part of the document is a list of names and addresses.

12. The twelfth part of the document is a list of names and addresses.

13. The thirteenth part of the document is a list of names and addresses.

14. The fourteenth part of the document is a list of names and addresses.

15. The fifteenth part of the document is a list of names and addresses.

16. The sixteenth part of the document is a list of names and addresses.

17. The seventeenth part of the document is a list of names and addresses.

18. The eighteenth part of the document is a list of names and addresses.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, the medical examiner must be notified and item 18 must be completed.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 3 4 2 0 8
REG. NO. | |
|---|--|---|--|--|--|--|--|--|--|-----------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Howard Easton Thompson | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 26, 1984 | | | 2b. HOUR
3:33 P.M. | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
11/13/01 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
83 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Executive | | 12b. KIND OF BUSINESS OR INDUSTRY
Banking | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
15608 Hackney Lane 20906 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Thompson | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Minnie A. Reeves | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | 16b. SOCIAL SECURITY NO.
578-03-8683 | | 17. INFORMANT
ADDRESS
Pleasanton, Calif. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular Accident
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Ischemic Cerebrovascular
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 years | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/26 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (they) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Daniel Golden | | | | DEGREE
MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12/26/84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Daniel Golden | | | | 22e. ADDRESS
10401 Old Georgetown Rd Bethesda, Md | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
12/31/1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland Maryland | | | | |
| 24. FUNERAL DIRECTOR
Joseph Gawler's Sons Inc. | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 3 1985 | | | | | | |
| 25b. REGISTRAR'S SIGNATURE
Gilia Davidson | | | | | | | | | | | |

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U. S. A. , Washington, D. C.

DIVISION

Page 10

Robertson, John.

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ROADS

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THE ASSOCIATED PRESS

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE RETURNED TO THE DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DMMH - 17
(VR A15 ME (5))
30M 7/73

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 34209 | | | | | |
|--|--|---------|-------------------|---|--|------------------------------------|--|--|----------------|---|--|---|--|-----------------------------|--|---------------|--|
| FOR STATE REGISTRAR | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH | | | MONTH DAY YEAR | | | 2b. HOUR P.M. | | | | | |
| Robert Warner Thompson | | | | | | Dec. 20, 1984 | | | | | | 7:41 P.M. | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH DAY YEAR | | 2d. HOUR P.M. | |
| Male | | White | | Feb. 21, 1923 | | 61 YRS. | | | | | | Dec. 20, 1984 | | | | 7:41 P.M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Wash. D.C. | | | | U.S.A. | | | | | | | | Montgomery County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Cabin John | | | | 7903 Woodrow Place | | | | Retired Correction Officer | | | | | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | |
| Maryland | | | | Montgomery | | Cabin John | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 7903 Woodrow Place 20818 | | | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | | | | | | | |
| Bertie W. Thompson | | | | Mary L. Magruder | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | | | | | | |
| Yes | | | | ww II | | | | Sterling Park, Va. 22170
Mary L. Windsor 1100 East Maple Ave. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | 4 1/2 mos. | | | | | |
| IMMEDIATE CAUSE (a) <u>Glioblastoma.</u> | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | | | |
| (b) _____ | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| (c) _____ | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | |
| None | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | | | |
| August 1984 | | | | For glioblastoma. | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| | | | | P.M. 19 | | | | None | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | | | | | |
| <i>John S. Rogers</i> | | | | M.D. Deputy | | | | 12/21/84 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | | | |
| John S. Rogers, M.D. | | | | 1919 Seminary Road | | | | Silver Spring, Montgomery, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | |
| Burial | | | | 12/24/84 | | Parklawn Memorial Park | | | | Rockville, Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Tyson Wheeler Funeral Home, Inc.
1331 Rockville Pike, Rockville, Md. 20852 | | | | | | | | | | | | | | <i>Shea Davidson-Rodell</i> | | | |

Montgomery County

2903 Woodrow Place

Cabin John

2903 Woodrow Place

Cabin John

Montgomery

Maryland

Gloucestershire

None

For Gloucestershire

August 1904

None

X

X

John S. Roberts, M.D.

Silver Spring, Montgomery, Md.

Deputy

1019 Seminary Road

12/21/54

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| 1- FOR STATE REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 34210 | | | |
|--|--|--|--|--|--|---|--|--|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Mary Hazel Tiefel | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12/24/84 | | | | 2b. HOUR
3:12A.M. | | | |
| 3. SEX
Female | | 4 RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
JUN 9, 1896 | | 6 AGE (IN YEARS LAST BIRTHDAY)
88 YRS. | | 7 IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | 8 IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Illinois | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | | |
| 10 CITY OR TOWN OF DEATH
Rockville | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Owner | | 12b. KIND OF BUSINESS OR INDUSTRY
Restaurant | | | |
| 13a. STATE
Florida | | 13b. COUNTY
Pinellas | | 13c. CITY OR TOWN
St Petersburg | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
6341 5th Avenue N. 33710 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Matthew J. Cross | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Laura Dwyer | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | | 17. INFORMANT (Son)
William R. Tiefel | | ADDRESS
P.O. Box 5650
Washington, D.C. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardio-Respiratory arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) <u>Cerebral Vascular Accident</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Cerebral Thrombosis</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>35'</u>
<u>72 hrs</u>
<u>72 hrs</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
<u>Pneumonia, old CVA + Hemiparesis</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/23/84</u> to <u>12/24/84</u> , that (I) (we) lost
saw the deceased alive on <u>12/23/84</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Stephen N. Jones</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12/24/84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Stephen N. Jones, MD | | | | 22e. ADDRESS
809 Viers Mill Rd., Rockville, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
December 27, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
St Mary Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Fairport New York | | | | | |
| 24 FUNERAL DIRECTOR
NAME
Robert A. Pumphrey | | | | 24b. FUNERAL HOME
P.A. Bethesda, Maryland | | | | 25a. DATE REC'D BY REGISTRAR
DEC 24 1984 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>Richard D. Jones</u> | | | | | | | |

Handwritten notes and faint printed text at the top of the page, including a date "1912" and some illegible lines.

Handwritten notes in the middle section, including a large "1" and some illegible text.



Vertical text on the right side of the page, possibly a title or a list of items, including the words "COLLECTION" and "LIBRARY".

BH

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 4 2 1 1

| | | | | | | | | | |
|--|--|--|---|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MARGARET GERARD TITUS | | | 2a. DATE OF DEATH MONTH DAY YEAR
DECEMBER 13, 1984 | | | 2b. HOUR
1:02 P M | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
APRIL 6, 1955 | | 6. AGE (IN YEARS LAST BIRTHDAY)
29 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
WASHINGTON, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4924 SENTINEL DRIVE #303 | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
ADMIN. ASST. | | 12b. KIND OF BUSINESS OR
BROKERAGE FIRM | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
BETHESDA | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
4924 SENTINEL DRIVE #303 (20816) | |
| 14. FATHER'S NAME
MIDDLE LAST
DOUGLAS JULES TITUS | | | | 15. MOTHER'S MAIDEN NAME
MIDDLE LAST
KATHLEEN O'HEARN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
X NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
219-64-0504 | | 17. INFORMANT (MOTHER) ADDRESS
MRS. KATHLEEN TITUS SAME AS ABOVE | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Glioblastoma Multiforme - Brain tumor</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>3 yrs</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>OCTOBER 1, 1982</u> to <u>DECEMBER 13, 1984</u> , that (X) (we) last saw the deceased alive on <u>DECEMBER 13, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>William J. Meyer, M.D., M.D.</u>
PHYSICIAN'S NAME (PRINT) | | | DEGREE <u>MD</u>
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
<u>12/14/84</u> | | | |
| 22b. ADDRESS
<u>William J. Meyer</u> | | | 22e. ADDRESS
NATIONAL INSTITUTES OF HEALTH
CLINICAL CENTER, BETHESDA, MARYLAND 20205 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | | | 23b. DATE
12/15/84 | | 23c. NAME OF CEMETERY OR CREMATORY
METROPOLITAN CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ALEXANDRIA, VIRGINIA | | |
| 24. FUNERAL DIRECTOR
NAME
RICHARD RAPP, INC. | | | ADDRESS
1804 T ST., N.W., WASHINGTON, D.C. 20009 | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson</u> | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

WASHINGTON, D.C. 20540

STORAGE
UNIT

ADMIN. ASST.

4024 RENTON DRIVE #202

CONTINUED

01 HEAVY

KATHLEEN

TYPE

RECE

OFFICE

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1804 J ST., N.W., WASHINGTON, D.C. 20009
RICHARD R. RAY, JR.
15/12/84
REPRODUCTION OPERATOR
ALLIANCE, VIRGINIA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 3 4 2 1 2 | | | |
|--|--|---|--|--|--|--|---|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) HENRIETTA J. TOLKOFF | | | | 2a. DATE OF DEATH MONTH 12 DAY 23 YEAR 84 | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH 3 DAY 17 YEAR 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS. IF UNDER 1 YEAR MONTHS 0 DAYS 0 IF UNDER 72 HRS. HOURS 0 MIN. 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CONN. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH Chevy Chase | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Retirement Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 13a. STATE MD. | | 13b. COUNTY Wash., DC | | 13c. STREET ADDRESS / ZIP CODE 3001 Veazey Terrace NW 20008 | | | |
| 14. FATHER'S NAME FIRST Abe MIDDLE Jacobs LAST Jacobs | | | | 15. MOTHER'S MAIDEN NAME FIRST Sadie MIDDLE Berger LAST Berger | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 262-80-1500 | | 17. INFORMANT ADDRESS Mr. Martin Tolcott Same As #13 | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CARDIAC ARREST | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 minutes |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRO-VASCULAR ACCIDENT | | | | | | | 1 hour |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: n/a | | | | | | | |
| 19a. DATE OF OPERATION _____ | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. _____ MONTH _____ DAY _____ YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) _____ | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) _____ | | 21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____ | | | |
| 22a. I certify that Dr. (this hospital) attended the deceased from 11/14 19 84 to 12/23 19 84 , that he (we) last saw the deceased alive on 11/23 19 84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE [Signature] | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 12/24/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CARE MARGOLIS | | 22e. ADDRESS 11404 OLGEGORGETOWN RD., Rockville, Md. 20857 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12/26/84 | | 23c. NAME OF CEMETERY OR CREMATORY Knollwood Pk Cemetery | | 23d. LOCATION Ridgewood, New York STATE NY | |
| 24. FUNERAL DIRECTOR Jos. Gawler's Sons 5130 Wisc. Av NW Wash., DC | | | | 25a. DATE REC'D. BY REGISTRAR DEC 31 1984 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

2000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1- STATE REGISTRAR | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 3 4 2 1 3 | | | | | |
|--|--|--|--|--|--|---|--|--|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Charles N. Tolson | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12 22 84 | | | | 2b. HOUR
1300 ^P | |
| 3 SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
April 17, 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 | | # UNDER 1 YEAR
MONTHS DAYS | | # UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | | |
| 10 CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13e. STREET ADDRESS / ZIP CODE
5200 Sangamore Road 20816 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Norman Nell | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Bessie Kauffman | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
N/A | | 17 INFORMANT (Daughter)
Pamela T. Allen | | ADDRESS 5200 Sangamore Rd. Bethesda, Maryland | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Artery Disease
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Cerebrovascular Accident</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>CARDIAC ARREST</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a
<u>None</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/19/84 to 12/22/84, that (I/we) last saw the deceased alive on 12/22/84, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Robert A. Hallowitz | | | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12/22/84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert A. Hallowitz | | | | 22e. ADDRESS
19211 Montgomery Village Ave B-24 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
December 23, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Alexandria Virginia | | | | | |
| 24 FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 24 1984 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

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Cleared By Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers, pages 1 and 2 should be kept within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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FOR
STATE
REGISTRAR

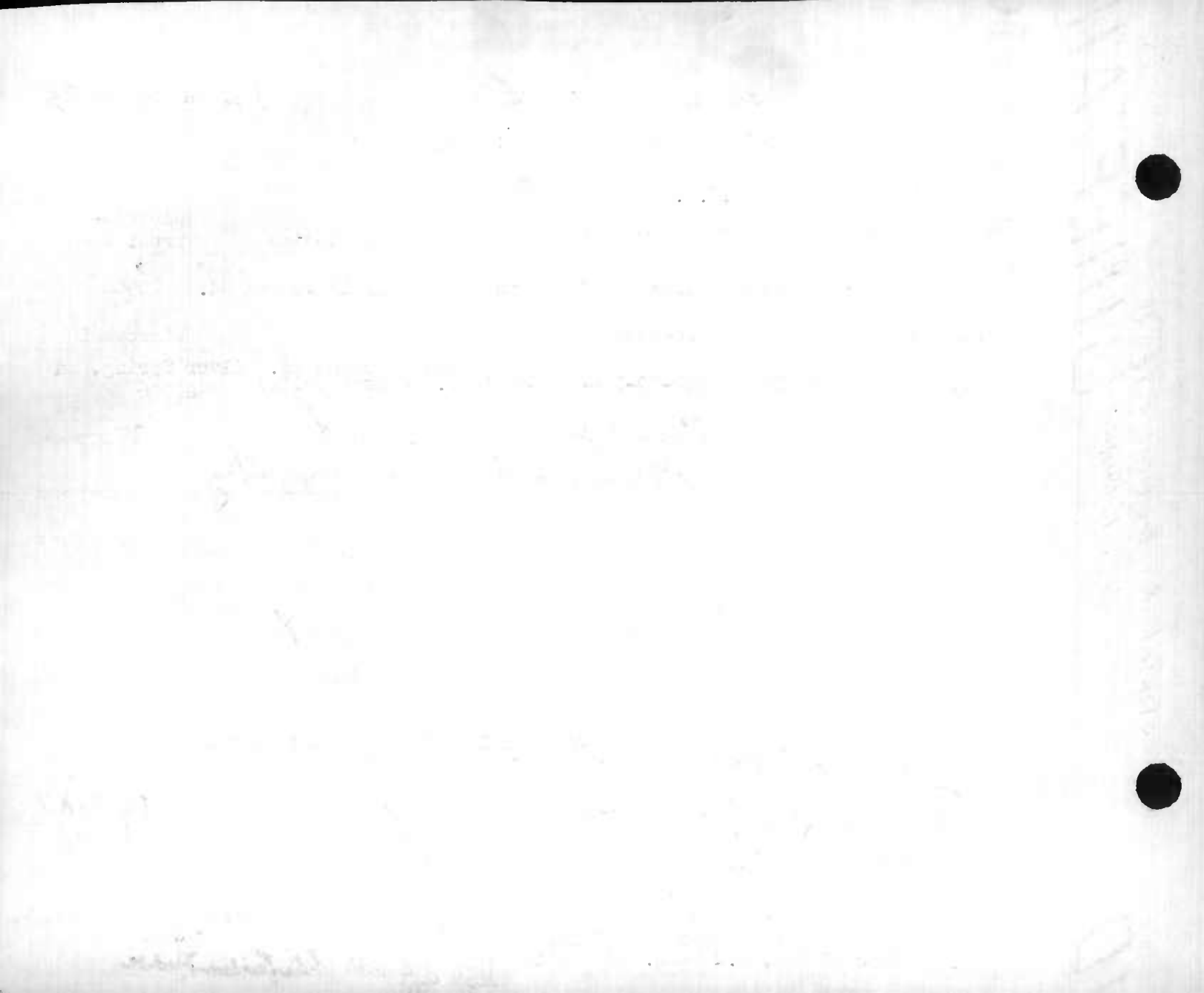
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 4 2 1 4

| | | | | | | | |
|---|--|--|---|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
STANLEY Joseph TOMCZAK | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 16 84 | | | 2b. HOUR
4 08 M | |
| 3. SEX
MALE | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 12 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Poland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NEW IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Custodian | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Tomczak | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sieropski | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE YEAR OR DATES)
WW II | | 17. INFORMANT
12314 Judson Rd. Silver Spring, Md
Sophie D. Tomczak (wife) 20906 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Cardiomyopathy</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
30 mins |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>November 18, 1984</u> to <u>December 16, 1984</u> , that (I) (we) last saw the deceased alive on <u>December 15, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Howard S. Goldstein</u> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/17/84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Howard S. Goldstein | | 22e. ADDRESS
4701 Randolph Rd. Rockville | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Removal | | 23b. DATE
12/17/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Georgetown Med School | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, DC | |
| 24. FUNERAL DIRECTOR
NAME
Columbia Mortuary Services, Inc
225 Missouri Ave, N.W. Wash. DC 20011 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 24 1984 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>John T. ...</u> | | | |

BP



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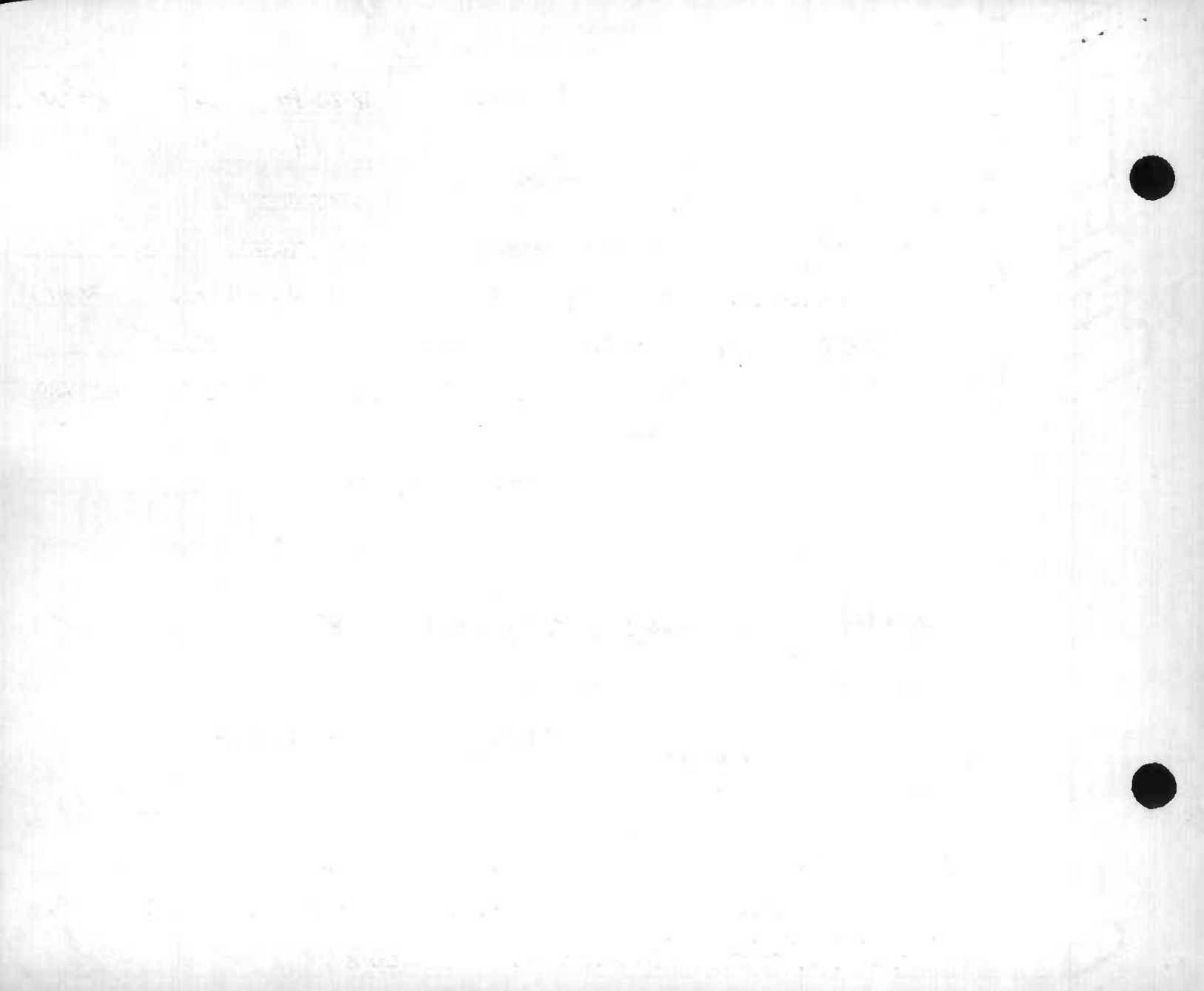
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

| FOR
1 - STATE
REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 3 4 2 1 5
REG. NO. | | | |
|--|--|---|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Gertrude Heath Trainor | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-20-84 7 15 84 | | | | 2b. HOUR
8:33 A.M. | | | |
| 3. SEX
female | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 - 15 - 10 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
WASH. D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park, MD | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
INVESTIGATOR | | 12b. KIND OF BUSINESS OR INDUSTRY
CREDIT BUREAU | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
9907 Edgehill Lane, 20901 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ERNEST M. CAVAN | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SARAH MILES | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
578-09-1253 | | 17. INFORMANT
I. VERNON TRAINOR | | | | ADDRESS
SAME AS 13 HUSBAND | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | | | | | | | |
| 19a. DATE OF OPERATION
12/14/84 | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
CORONARY artery disease | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/12/84 , 19____, to 12/20/84 , 19____, that (I) (we) last saw the deceased alive on 12/20/84 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
B. H. LEVIN, M.D. | | | | DEGREE
WASHINGTON ADVENTIST HOSPITAL | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/20/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
B. H. LEVIN, M.D. | | | | 22e. ADDRESS
WASHINGTON ADVENTIST HOSPITAL | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | | 23b. DATE
12/22/84 | | 23c. NAME OF CEMETERY OR CREMATORY
PARKLAWN CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ROCKVILLE MONT MD. | | | |
| 24. FUNERAL DIRECTOR FRANCIS J. COLLINS
NAME ADDRESS
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 24 1984 | | 25b. REGISTRAR'S SIGNATURE
J. Davidson-Randall | | | |



STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

 3 4 2 1 6
 REG. NO.

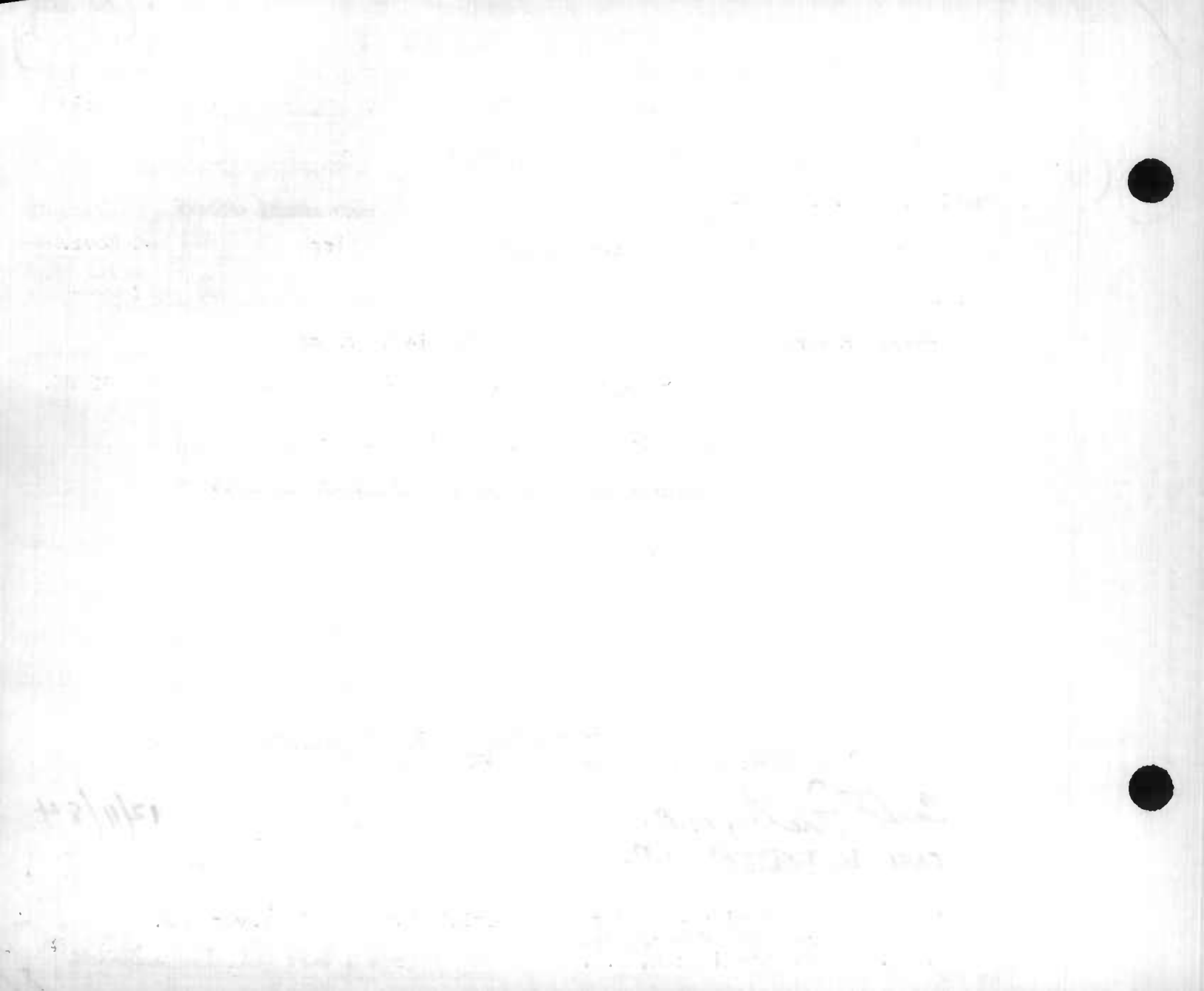
| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1 - FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| | | ALMADEUS ORESTES TRAVERS | | DECEMBER 10, 1984 | | 4:15 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| MALE | | NEGRO | | MAY 16, 1961 | | 23 YRS | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Washington, D.C. | | USA | | | | MONTGOMERY COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BETHESDA | | NIH, THE CLINICAL CENTER | | Clerk | | DC Govt. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| D.C. | | | | WASHINGTON | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 13e. STREET ADDRESS / ZIP CODE | | | |
| Robert Travers | | Fannie Lawrence | | 840 18th STREET NE | | 20002 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| no | | 579-84-0683 | | ROBERT TRAVERS, FATHER | | SAME AS PT. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Widely metastatic osteogenic sarcoma</u> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Respiratory failure (by clinical history)</u> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22. I certify that (a) (this hospital) attended the deceased from <u>August 18</u> , 19 <u>78</u> , to <u>DECEMBER 10</u> , 19 <u>84</u> , that <u>X</u> (we) lost saw the deceased alive on <u>DECEMBER 10</u> , 19 <u>84</u> , and that in <u>XX</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>X</u> (we) did not see the body after death. | | | | | | | |
| 27a. SIGNATURE <u>Carl E. Freter, M.D.</u> | | | | DEGREE | | 27c. DATE SIGNED | |
| 27b. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 12/11/84 | |
| CARL E. FRETER, M.D. | | | | 27e. ADDRESS | | | |
| | | | | NATIONAL INSTITUTES OF HEALTH | | | |
| | | | | BETHESDA, MARYLAND | | 20205 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 12-15-84 | | Harmony Memorial Park | | Landover, Md. | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Marshall's Funeral Home | | | | DEC 17 1984 | | Julia Davidson-Randall | |
| 4217 9th St NW: Washington, D.C. | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 34217 | |
|--|--|--|--|---|--|---|--|---|--|----------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT)
Lois Virginia Trigg | | | | | | 2c. DATE OF DEATH
MONTH DAY YEAR
12 9 84 | | 2b. HOUR
11 M | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb. 20, 1924 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Missouri | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF IN HOSPITAL, GIVE NAME AND ADDRESS)
263 Congressional Lane #302 | | | | 12a. USUAL OCCUPATION
(TYPE OR PRINT, EXCEPT WORKING LIFE)
Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY
N.I.H. | | | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13e. STREET ADDRESS
263 Congressional Lane #302 | | | | 13f. ZIP CODE
20850 | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Earl Leon Ragar | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mabel Kathryn Martin | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
500-16-8378 | | 17. INFORMANT
Gaithersburg, Md. 20878
Kathy Sponseller 132 Bent Twig Lane | | | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF
(b) CORONARY HEART DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 years. | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
HYPERTENSION | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/10 , 19 82 , to 12/9 , 19 84 , that (I) (we) last saw the deceased alive on 12/5 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (they) did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
JOEL A. RAISKAL, MD | | | | 22c. DATE SIGNED
12/9/84 | | | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| 22e. ADDRESS
50 W. EDMONDSON DRIVE
ROCKVILLE, MD 20852 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
12/11/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland, Maryland | | | | | |
| 24. FUNERAL DIRECTOR
Tyson Wheeler Funeral Home, Inc.
1331 Rockville Pike, Rockville, Md. 20852 | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 13 1984 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

| | | | |
|-----------|----------------------|---------------|------|
| Count | White | Feb. 20, 1924 | 19 |
| Resident | U. A. A. | | |
| Rossville | 1203 Commercial Lane | 2024 | 1924 |
| Marion | Woodman | Rossville | 1924 |
| Marion | 1001 | Marion | 1924 |
| Marion | 1001 | Marion | 1924 |



1001
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 1001

1001

1001
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 1001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 48 shows any injury, or other traumatic event, the medical examiner must be notified and a medical investigation conducted.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 3 4 2 1 8
REG. NO. | | | |
|--|--|---|--|---|---|---|--|--|--|--|--|---------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | 1. DECEASED NAME
(TYPE OR PRINT) AGNES G. TUNIMAN | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-20-84 | | 2b. HOUR
1205 M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 21, 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | | 8. IF UNDER 1 YEAR
MONTHS DAYS | | 9. IF UNDER 24 HRS
HOURS MIN. | | | |
| 7a. BIRTHPLACE
(COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | | | |
| 11. CITY OR TOWN OF DEATH
Bethesda | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Mary's Leonardtown | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | | 13b. CITY OR TOWN
St. Mary's | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE
P.O. Box 164 (20650) | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Clements | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rosa Jarboe | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | | |
| 16b. SOCIAL SECURITY NO.
213-50-7273 | | | | 17 INFORMANT
Rose Mary Tuiman, Bethesda, Md. | | | | ADDRESS 10406 Montrose Ave 20814 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Squamous Cell Carcinoma of Larynx - METASTATIC | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 1/2 yrs | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Carcinoma of LARYNX 13 yrs ago | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 11, 1984 to Dec 21, 1984 , that (I) (we) last saw the deceased alive on 20 Dec 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Eugene P. Libre MD | | | | DEGREE MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
20 Dec 84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Eugene P. Libre MD | | | | 22e. ADDRESS
10400 CONNECTICUT Ave, KENSINGTON, MD. 20885 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
12/24/84 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Aloysius Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Leonardtown, St. Mary's Md | | | | | |
| 24. FUNERAL DIRECTOR
NAME
W. Clarke Mattingley, Leonardtown, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 31 1984 | | 25b. REGISTRAR'S SIGNATURE
John Davidson, Registrar | | | | | |

BP

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10/10/1917

10/10/1917

4x1

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 34219 | |
|---|--|-------------------------|--|---|--|--|--|---|--|---|--|----------------|--|
| 1- STATE REGISTRAR | | | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
EDWARD LEE TURNER | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
12-1-84 | | 2b. HOUR
3:01AM | | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
01 07 40 | | 6. AGE (IN YEARS)
LAST BIRTHDAY
44 YRS. | | 7. IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN
12-1-84 | | 2c. DATE PRONOUNCED DEAD
12-1-84 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VIRGINIA | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
CHAUFFEUR | | 12b. KIND OF BUSINESS OR INDUSTRY
CAB CO. | | | |
| 13a. STATE
VIRGINIA | | | | 13b. CITY OR TOWN
ARLINGTON | | 13c. CITY OR TOWN
ARLINGTON | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3008 NORTH 5TH STREET | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ALVA RODNEY TURNER | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
EVELYN CARLYLE RICHARDSON | | | | 16. SOCIAL SECURITY NO.
227-50-5495 | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, GIVE WAR OR DATES
VIETNAM | | | | 17. INFORMANT
ADDRESS
DOUGLAS E. TURNER 11619 SMITHFIELD ROAD | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that took charge of the remains described above, held on death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Thomas D. Smith</i> | | | | TITLE (SPECIFY)
M.D. Deputy Chief MEDICAL EXAMINER | | | | DATE SIGNED 12-2-84 | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Thomas D. Smith, M.D. | | | | ADDRESS
111 Penn Street | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | | 23b. DATE
12-04-84 | | 23c. NAME OF CEMETERY OR CREMATORY
CREST LAWN MEM. GARDENS | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
MARRIOTTSTVILLE HOWARD MD. | | | |
| 24. FUNERAL DIRECTOR
NAME
HUBBARD FUNERAL HOME, INC. | | | | ADDRESS
4107 WILKENS AVE. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 3 1984 | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | | |

17k

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 656-5050.

DHMH-16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 3 4 2 2 0
REG. NO. | |
|---|--|---|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Evelyn Elizabeth Tyler | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
Dec. 30 1984 | | 2b. HOUR
2:20 a.m. | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
May 19 1909 | | 6. AGE (IN YEARS, LAST BIRTHDAY)
75 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3331 Hewitt Avenue Apt. #104 | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3331 Hewitt Avenue Apt. #104 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
David Abner Mullens | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Rhoda Ann Mullens | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | | |
| 16b. SOCIAL SECURITY NO.
572-46-9455 | | 17. INFORMANT ADDRESS
Larry Allen Tyler Same as items 13a-e | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bile duct carcinoma with metastases to the liver
DUE TO, OR AS A CONSEQUENCE OF (b) congestive heart failure
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 months | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: | | | | | | | | | | | |
| 19a. DATE OF OPERATION
11-5-84 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Bile duct carcinoma | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from September 19 1984 to December 19 1984 that (I) (we) last saw the deceased alive on November 19 1984 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Gary M. Roggin MD | | | | DEGREE
MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/31/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Gary M. Roggin | | | | 22e. ADDRESS
10215 Fernwood Rd. Bethesda, Md. 20817 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1/3/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Memorial Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Rockville, Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME
Tyson Wheeler Funeral Home, Inc. | | | | 24b. ADDRESS
1331 Rockville Pike Rockville, Maryland 20852 | | 25a. DATE REC'D. BY REGISTRAR
JAN 7 1985 | | 25b. REGISTRAR'S SIGNATURE
Jana Davidson-Hendall | | | |

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1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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Barry Allen Tyler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
David Edgar Utz | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 31 84 | | | 2b. HOUR
09:45 P.M. | |
| 3. SEX
Male | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
SEPT 24, 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASHINGTON, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RECORDS MANAGER | |
| | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY
HOUSING ADM. | |

| | | | | | | | | |
|---|--|--|--|--|--|---|--|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | 13b. COUNTY
MONTGOMERY | | | 13c. CITY OR TOWN
SILVER SPRING | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
THOMAS A. UTZ | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNKNOWN | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET ADDRESS
15300 PINE ORCHARD DRIVE 20906 | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | | 16b. SOCIAL SECURITY NO.
WW II 216-44-6657 | | | 17. INFORMANT
ADDRESS
BERNICE UTZ SAME AS 13 WIFE | | |

| | | | |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardio Respiratory Arrest</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Metastatic Anaplastic Carcinoma</u> | | ~ 1 month | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | |

| | | | |
|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
<u>Coronary Artery Disease, Congestive Heart Failure</u> | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 17</u> , 19 <u>84</u> , to <u>Dec 31</u> , 19 <u>84</u> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <u>Dec 31</u> , 19 <u>84</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (did not) view the body after death. | | | |
| 22b. SIGNATURE
<u>Roger F Leonard</u> | | 22c. DATE SIGNED
1/1/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Roger F Leonard | | 22e. ADDRESS
1040 Old Georgetown Rd, Bethesda MD | |

| | | | | | | | |
|--|--|---------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
1/3/85 | | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
SILVER SPRING MONT MD. | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 4 1985 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | | |

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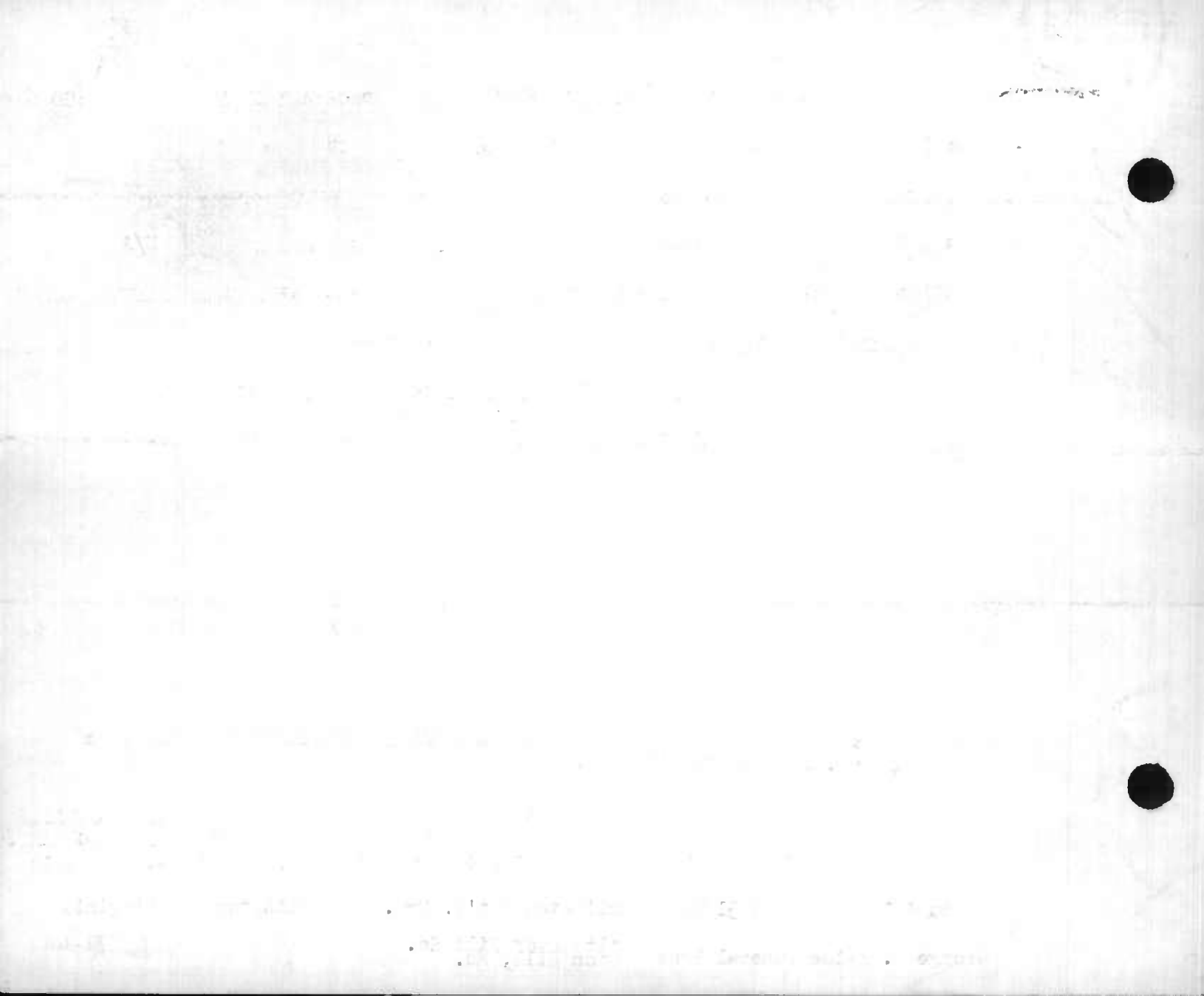
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 4 2 2 2
REG. NO.

| | | | | | | | | | | |
|---|--|--|--|---|--|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
GOLDIE FERN VAN HISE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 27 1984 | | | 2b. HOUR
P M
4:00 P | | | | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
MAY 2 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
89 | | 7. IF UNDER 1 YEAR
IF UNDER 24 HRS.
HOURS MIN.
0 0 0 | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
KANSAS | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
N/A | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | 13b. COUNTY
PRINCE GEO'S | | | 13c. CITY OR TOWN
TEMPLE HILLS | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
2900 SAINT CLAIR DRIVE 20748 | | | 14. FATHER'S NAME
FIRST MIDDLE LAST
JAMES NOAH YATES | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY TRUSKY | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | 16b. SOCIAL SECURITY NO.
577-30-8959 | | | 17. INFORMANT
ADDRESS
GRACE H. LEOFFIER, 3730 48th STREET, NW, WASHINGTON, DC 20016 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) HEPATIC CIRROHSIS
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from DECEMBER 4 , 19 84 , to DECEMBER 27 , 19 84 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on DECEMBER 27 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
B. L. FLAX | | | | | | DEGREE
MD | | 22c. DATE SIGNED
28 DEC 1984 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
B. L. FLAX, LT, MC, USNR | | | | | | 22e. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
12/31/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington Nat'l. Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington Virginia | | | |
| 24. FUNERAL DIRECTOR
NAME
George P. Kalas Funeral Home | | | | | | ADDRESS
6160 Oxon Hill Rd. Oxon Hill, Md. | | 25a. DATE REC'D. BY REGISTRAR
DEC 31 1984 | | |
| 25b. REGISTRAR'S SIGNATURE
W. Davidson-Randall | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified.



| FOR
1 - STATE
REGISTRAR | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | 3 4 2 2 3
REG. NO. | |
|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2b. DATE OF DEATH MONTH DAY YEAR | |
| SONJA ELISABETH VAN HOLST PELLEKAAN | | | | 12/13/84 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | |
| Female | | Caucasian | | MONTH DAY YEAR | |
| | | | | July 23, 1968 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| 16 | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Australia | | Australia | | Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Silver Spring | | 10,000 Sutherland Rd, Silver Spring | | Student | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS / ZIP CODE | | 13b. CITY OR TOWN | |
| N/A | | 10000 Sutherland Rd - 20921 | | Silver Spring | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES NO OR UNKNOWN) | |
| Jack Walter Van Holst Pellekaan | | Freya Susanne Edmeades | | NO | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| 216-94-0532 | | mother / | | same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | |
| PART I. DEATH WAS CAUSED BY | | | | | |
| IMMEDIATE CAUSE (a) Heart failure (myocardial infarction) | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (b) Pericardial metastases | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) Osteogenic Sarcoma | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | |
| None | | | | | |
| 19a. DATE OF EXAMINATION | | | | | |
| July 13, 1984 | | | | | |
| 19b. CONDITION OF DECEASED AT TIME OF EXAMINATION | | | | | |
| Thoracotomy - Resection | | | | | |
| 20a. AUTOPSY? | | | | | |
| YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. TIME OF INJURY | | | | | |
| HOUR A.M. MONTH DAY YEAR | | | | | |
| N/A | | | | | |
| 21b. PLACE OF INJURY | | | | | |
| (AT HOME STREET FACTORY, OFFICE FARM, ETC.) | | | | | |
| N/A | | | | | |
| 21c. HOW INJURY OCCURRED | | | | | |
| (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| N/A | | | | | |
| 21d. LOCATION | | | | | |
| STREET CITY OR TOWN COUNTY STATE | | | | | |
| N/A | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from March 1984 to present and that (2) my opinion of death occurred on the date and hour and from the causes stated above. | | | | | |
| 22b. SIGNATURE | | | | | |
| Peter S. Birk, M.D. | | | | | |
| 22c. DATE SIGNED | | | | | |
| 12/13/84 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | |
| PETER S. BIRK, M.D. | | | | | |
| 22e. ADDRESS | | | | | |
| 10829 Ga. Av., Silver Spring, MD. 20902 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| CREMATION | | 12/15/84 | | METROPOLITAN CREMATORY | |
| | | | | ALEXANDRIA, VIRGINIA | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| RICHARD RAPP, INC.
1804 T ST., N.W., WASHINGTON, D.C. 20009 | | DEC 17 1984 | | Julia Davidson-Rendell | |

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MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1804 T ST., N.W., WASHINGTON, D.C. 20009
RICHARD S. GALT, INC.
CREATION DESIGN GROUP
ALEXANDRIA, VIRGINIA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/83
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|---|---|---|---|--|--|--|
| 1. FOR STATE REGISTRAR Panos George Vassiliades | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) PANOS George VASSILIADIS | | | | | 2a. DATE OF DEATH
MONTH 12 DAY 24 YEAR 84 | | 2b. HOUR
4 14 AM | | |
| 3. SEX
MALE | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH 10 DAY 26 YEAR 21 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Manufacture Rep. | | 12b. KIND OF BUSINESS OR INDUSTRY
Vass Sales Co. | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
5704-Greentree Road 20817 | |
| 14. FATHER'S NAME
FIRST George MIDDLE - LAST Vassiliades | | | | 15. MOTHER'S MAIDEN NAME
FIRST Evangeline MIDDLE - LAST Orfanos | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO.
579-18-8826 | | 17. INFORMANT
ADDRESS
Mary Garland Vassiliades (Wife) Same as #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c) Metastatic Bladder Cancer
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/29 , 19 84 , to 12/24 , 19 84 , that (I) (we) last saw the deceased alive on 12/23 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Adam Black | | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
12/24/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ADAM BLACK | | | | | 22e. ADDRESS
10500 Summit Ave, Kensington, MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | | 23b. DATE
12-24-1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Lee's Crematory | | 23d. LOCATION
CITY OR TOWN Washington, D.C. COUNTY STATE | | |
| 24. FUNERAL DIRECTOR
NAME J. Wm. Lee's Sons Co. ADDRESS 300-4th St., NE, Wash., DC 20002 | | | | | | | | | |
| DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
31 1984 John Davidson | | | | | | | | | |

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George Washington

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 3 4 2 2 5 | | | | | | | | | |
|--|--|------------------|--|---|--|--|--|--|--|---|--|--|--|--|--|--------------------------------------|--|---|--|---|--|
| 1- STATE REGISTRAR | | | | | | | | | | | | | | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
John H. Vaughn | | | | | | | | | | 2a. DATE KNOWN OF DEATH | | MONTH DAY YEAR
12 19 84 | | 2b. HOUR OF DEATH
12:16 P M | | | | | | | |
| 3 SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
7 9 20 | | 6 AGE (IN YEARS) (LAST BIRTHDAY)
64 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
12 19 84 | | 2d. HOUR
12:16 P M | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Alabama | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH
Bethesda | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret Lt Col | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Military | | | | | | | | | |
| 13a. STATE
Virginia | | | | | | | | | | | | | | 13b. COUNTY
Fairfax | | 13c. CITY OR TOWN
Annandale | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
4704 Kingston Drive 9999 | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
John W. Vaughn | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Pearl Streetman | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
1942-1967 | | | | 17. INFORMANT
Spouse | | | | ADDRESS
same as above | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } coronary arteriosclerosis
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE John Touben | | | | | | | | | | TITLE (SPECIFY)
M.D. Deputy | | MEDICAL EXAMINER | | DATE SIGNED 12-19-84 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
John Touben | | | | ADDRESS
8218 Wisconsin Ave Bethesda | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
Dec. 24, 84 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington Nat'l Cem. | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington, Virginia | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Demaime Funeral Homes, Inc | | | | | | | | | | ADDRESS
Alexandria, Virginia | | 25. DATE RECEIVED BY REGISTRAR
DEC 31 1984 | | | | REGISTRAR'S SIGNATURE
John Touben | | | | | |

2-4-44 Kingston Dr. Va

James E. Harrison

John

10-1-44

James

Virginia

John

2-4-44 Kingston Dr. Va

11-11-44

11-11-44

11-11-44



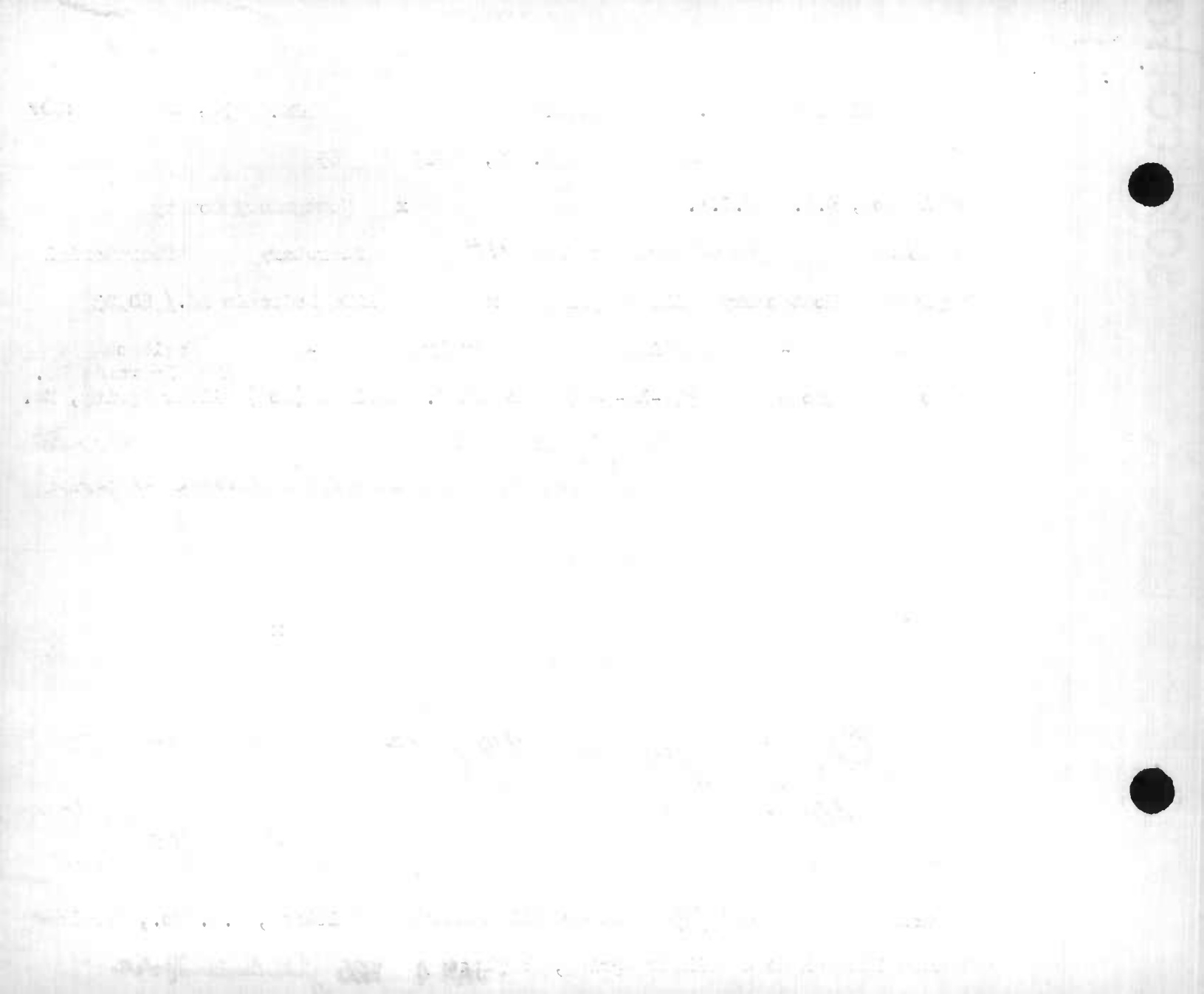
Dec. 22, 44

James E. Harrison

James E. Harrison, 111

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH342226
REG. NO.

| | | | | | |
|---|--|--|---|--|--------------------------------|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| VIRGINIA D. VOSBURGH | | DEC. 31, 1984 | | 6:00 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE | 7. BALTIMORE CITY OR COUNTY OF DEATH | |
| FEMALE | White | Sept. 2, 1919 | 65 YRS | Montgomery County MD. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Washington, D.C. | U.S.A. | | Montgomery County MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Wheaton | RANDOLPH HILLS NH. | | Secretary | Secretarial | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
| Maryland | Montgomery | Silver Spring | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 1206 LaGrande Rd. / 20903 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | |
| George - Darling | | Evelyn - Jamieson | | 16b. SOCIAL SECURITY NO. | |
| | | | | 577-16-5487 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | 577-16-5487 | | Robert F. Jennings (Son) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>Heart failure</u> | | IMMEDIATE CAUSE (a) <u>Heart failure</u> | | 1 month | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic cardiovascular disease 4 years</u> | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF (c) | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY | | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | HOUR A.M. MONTH DAY YEAR | | | |
| | | P.M. 19 | | | |
| 21a. INJURY OCCURRED | | 21b. PLACE OF INJURY | | 21c. LOCATION | |
| WHILE <input type="checkbox"/> AT WORK NO: WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | [AT HOME STREET FACTORY OFFICE FARM, ETC.] | | STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (b) (this hospital) attended the deceased from <u>12/31</u> 19 <u>84</u> to <u>12/31</u> 19 <u>84</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated | | 22b. SIGNATURE | | 22c. DATE SIGNED | |
| | | <u>B.N. ROSENBAUM, M.D.</u> | | 12/31/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 22f. DATE REC'D. BY REGISTRAR | |
| B.N. ROSENBAUM | | 3720 FARRAGUT AVE. KENSINGTON, MD. 20895 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | Dec/3/85 | | Cedar Hill Cemetery | |
| 24. FUNERAL DIRECTOR | | 24b. DATE REC'D. BY REGISTRAR | | 24c. REGISTRAR'S SIGNATURE | |
| NAME ADDRESS | | | | | |
| Chambers Funeral Home Silver Spring, Maryland | | JAN 4 1985 | | John D. ... | |



RELEASED BY D. TAUBER

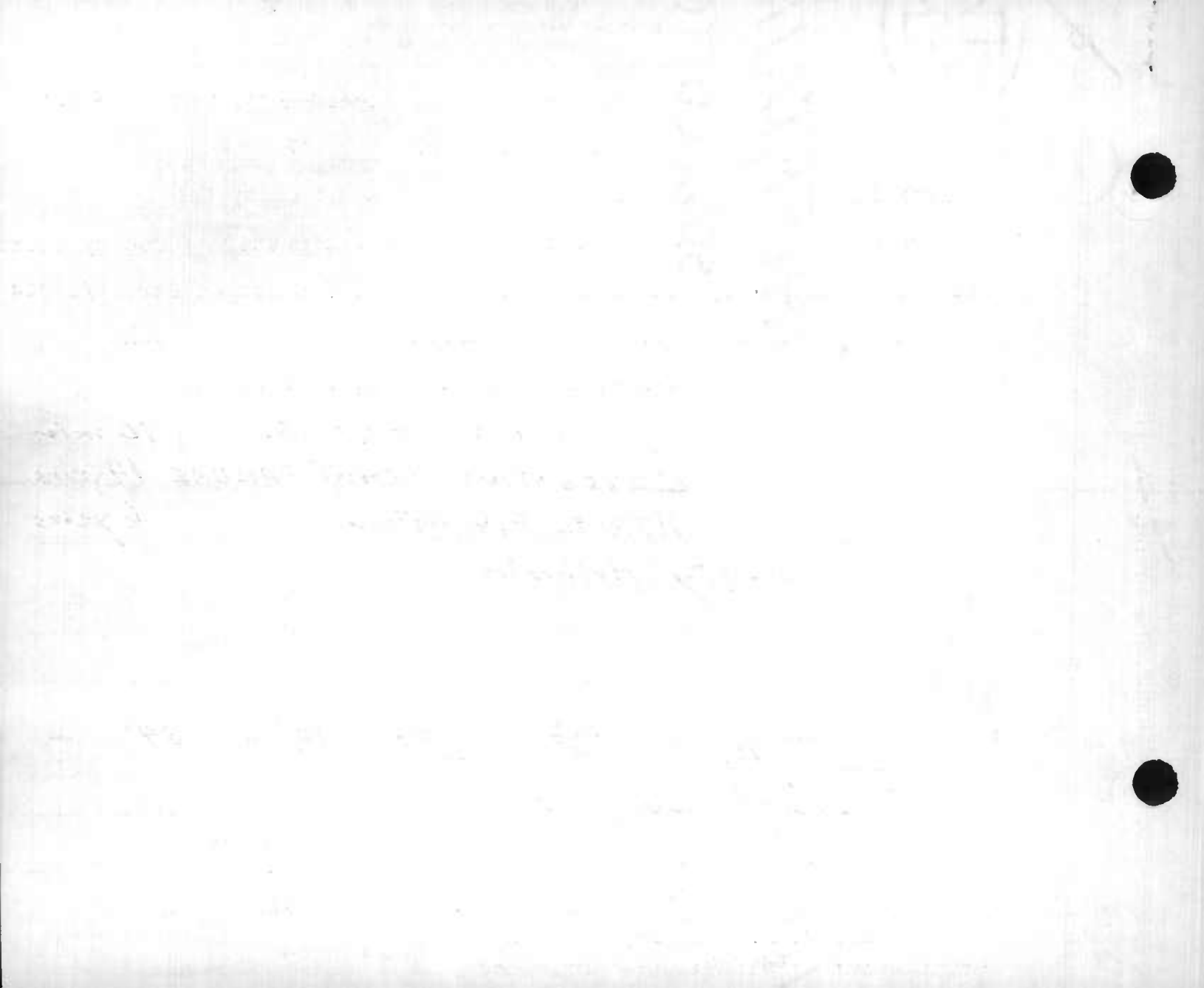
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Department of Health with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 34227
REG. NO. | |
|---|--|---|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Samuel C. Wade | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
December 15, 1984 | | 2b. HOUR
4:56 AM | |
| 3 SEX
Male | | 4 RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
Sept. 21, 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | | |
| 10 CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Meat Cutter | | 12b. KIND OF BUSINESS OR INDUSTRY
Grocery Store | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. CITY OR TOWN
Montgomery | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE
4607 Chestnut Street/20814 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Samuel Felix Wade | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Nannie Peake | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
577-18-7518 | | 17 INFORMANT ADDRESS
Anna L. Wade, same as #13 | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>10 min</u> | |
| DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | (b) <u>CONGESTIVE HEART FAILURE</u> <u>14 years</u> | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) <u>ATRIAL Fibrillation</u> | | | | | | | | | | <u>6 years</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Coarctation Aortic</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>12/10</u> , 19 <u>84</u> , to <u>12/15</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>12/10</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <u>(did not)</u> view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Frank Y. Jaggers</u> | | | | 22c. DATE SIGNED
Dec. 15, 1984 | | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Frank Y. Jaggers, M.D. | | | |
| 22e. ADDRESS
6000 Executive Blvd
Rockville, Maryland 20852 | | | | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Dec. 18, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Mem. Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville, Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME
Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland 20814 | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 18 1984 | | 25b. REGISTRAR'S SIGNATURE
<u>John Davidson-Randall</u> | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 3 4 2 2 8
REG. NO. | |
|--|--|--|--|---|--|---|--|---|------------------------|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Paul Louis Wagner | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 12-1-1984 | | | 2b. HOUR 1:58 P | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 5-31-11 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Massachusetts | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Holy Cross Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) self-employed sign painter | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Garrett Park | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 11205 Rokeby Ave. 20896 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles L.H. Wagner | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine G. Smith | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 028-05-0767 | | 17. INFORMANT ADDRESS Thelma L. Wagner same as 13e | | | | | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Cardiac Arrest 2° Vent. Tachycardia
DUE TO, OR AS A CONSEQUENCE OF (b) myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7 hours
2 years
25 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Mycoplasma pneumoniae, latent infection | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 1/13 19 78 , to 12/1 19 84 , that (1) (we) last saw the deceased alive on 12/1 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Max G. Sherer MD | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 12/1/84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MAX G. SHERER MD | | | | 22e. ADDRESS 500 BERSHING DR. Silver Spring, Md 20910 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12/5/84 | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland | | | | | |
| 24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Md. 20852 | | | | | | 25a. DATE REC'D. BY REGISTRAR DEC 6 1984 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

20% COTTON FIBRE

WILSON



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Knoxville Paper Co., Inc.
Dept. of Paper, Knoxville, Tenn.
Knoxville, Tenn. 37802

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 34229 | |
|---|--|---|--|---|--|---|--|--|--------------------|--------------------------------|--|
| 1. FOR STATE REGISTRAR | | I. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Rose B. Wagner | | | | 2a. DATE OF DEATH MONTH DAY YEAR
December 14, 1984 | | | 2b. HOUR
11:00P | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb. 8, 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Potomac | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
12220 McCrossin Lane | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Potomac | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
12220 McCrossin Lane/20854 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Thomas Nichols | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sally Mayhew | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | |
| 16b. SOCIAL SECURITY NO.
214-76-7079 | | | | 17. INFORMANT
ADDRESS
15105 Old ColumbiaPk
Leonard A. Harter Burtonsville, MD | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Laryngo-tracheo-bronchitis</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) <u>Allergic bronchitis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Hours</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>H.C.V.D. Obesity-severe</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) <u>(the hospital)</u> attended the deceased from <u>12-5</u> , 19 <u>84</u> , to <u>12-15</u> , 19 <u>84</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>12-5</u> , 19 <u>84</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Sack Schumacher MD.</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
<u>12-15-84</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Sack Schumacher</u> | | | | 22e. ADDRESS
<u>105 Russell Ave.
Gaithersburg, Md.</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Dec 18, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Mem. Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville, Maryland | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland 20850 | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 18 1984 | | 25b. REGISTRAR'S SIGNATURE
<u>Davidson</u> | | | |

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Alleged to be

H. C. D. County - 1901

1901

Jack Schumann

Jack Schumann

1901

1901

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 4 2 3 0
REG. NO.

| | | | | | |
|--|---|---|---|--|---|
| 1. FOR
STATE
REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | MONTH DAY YEAR | | HOUR MIN. | |
| Marie Magdeline Wallmark | | 12-12-84 | | 2 ⁵⁰ A.M. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE | 7. IF UNDER 1 YEAR | |
| Female | Caucasian | December 31, 1899 | 84 YRS. | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE
(COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Washington, D.C. | United States | | MONTGOMERY County, MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| BETHESDA | SUBURBAN HOSPITAL | | Secretary | | U.S. Gov't |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | |
| Maryland | Montgomery | Bethesda | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| William R. Montgomery | | Mary A. Soper | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 579-42-6818 | | Mrs. Mabel A. Nelson, Daughter, Same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) <u>arrhythmia</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (b) <u>peritonitis</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) <u>renal failure</u> <u>S/P hemicolectomy</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| <u>S/P hemicolectomy</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| 11/30/84 | | S/P perforated colon | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| | | P.M. / 19 | | | |
| 21d. INJURY OCCURRED
AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/30/84</u> 19 <u>84</u> to <u>12/12/84</u> 19 <u>84</u> , that (I) (we) lost
saw the deceased alive on <u>12/11/84</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| <u>K. NOSSULI</u> | | <u>MD</u> | | <u>12/22/84</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| <u>K. NOSSULI</u> | | <u>11500 Old Georgetown Rd - Rockville MD</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | December 14, 1984 | | Mt. Olivet Cemetery | |
| 24. FUNERAL DIRECTOR
NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Robert A. Pumphrey Funeral Homes,
P.A., Bethesda, Maryland | | DEC 17 1984 | | <u>J. Davidson-Randall</u> | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

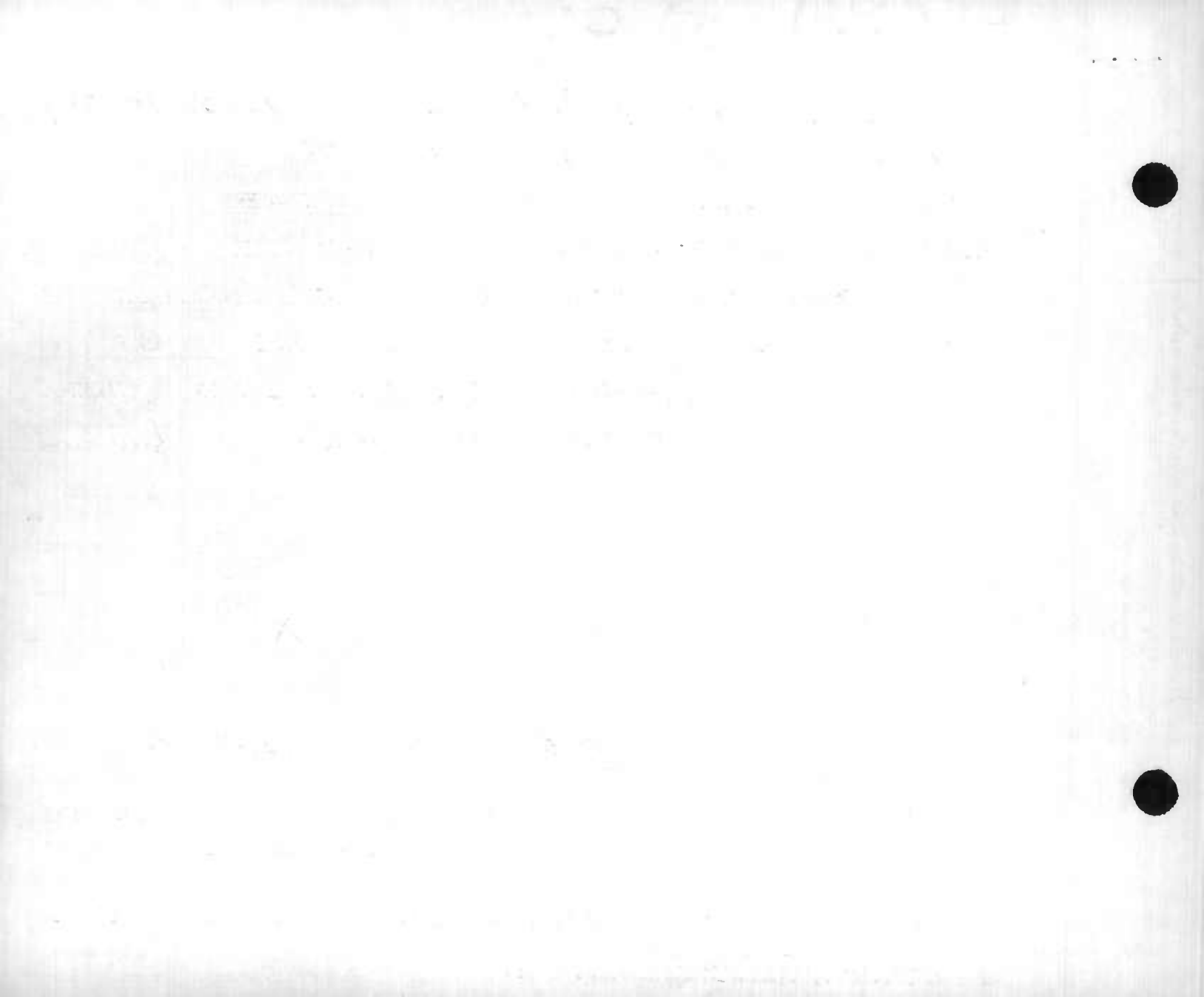
| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 3 4 2 3 1 | |
|--|--|---|--|---|---|--|---|---|--|--------------------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Joseph Phillip Waters, Sr.</i> | | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>12-27-84</i> | | | 2b. HOUR <i>2:50 PM</i> | | | |
| 3. SEX <i>MALE</i> | | 4. RACE <i>WHITE</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>9-2-06</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>78</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>PENNSYLVANIA</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY</i> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH <i>TAKOMA PARK</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>WASHINGTON ADVENTIST HOSPITAL</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>TRUCK DRIVER</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>SYNDERS CO.</i> | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE <i>MARYLAND</i> | | 13b. CITY OR TOWN <i>PRINCE GEO.</i> | | 13c. CITY OR TOWN <i>HYATTSVILLE</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE <i>631 SHERIDAN STREET 20783</i> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>JOSEPH P. WATERS</i> | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>ELLA JANE LONG</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i> | | 16b. SOCIAL SECURITY NO. <i>578-09-1018</i> | | 17. INFORMANT ADDRESS <i>ANITA G. WATERS SAME AS 13 DAUGHTER</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Metastatic melanoma</i>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>few months</i> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/26</i> 19 <i>84</i> to <i>12/27</i> 19 <i>84</i> , that (I) (we) lost
saw the deceased alive on <i>12/27</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>Antonio G. Uy</i> | | | | DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED <i>12/27/84</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ANTONIO G. UY</i> | | | | 22e. ADDRESS <i>831 Union Blvd E # 2 S.S. Md 20903</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>CREMATION</i> | | 23b. DATE <i>12/28/84</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>METROPOLITAN CREMATORY</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>ALEXANDRIA VIRGINIA</i> | | | | | |
| 24. FUNERAL DIRECTOR NAME <i>FRANCIS J. COLLINS</i> ADDRESS <i>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</i> | | | | 25a. DATE REC'D. BY REGISTRAR <i>JAN 4 1985</i> | | 25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 must be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is given any injury, or other traumatic event, the medical examiner will be notified of this.



BP

DHMH - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

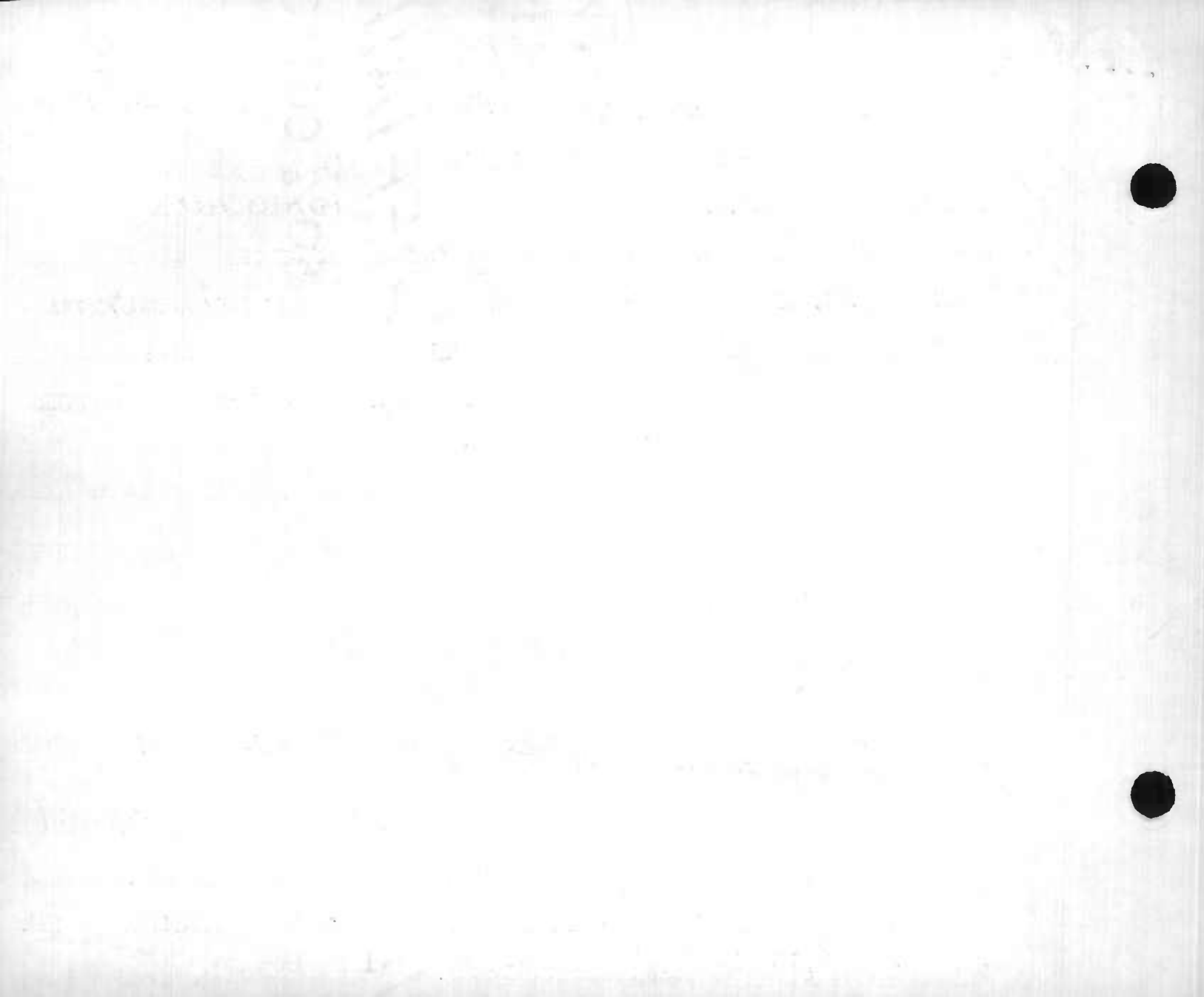
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 4 2 3 2

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ELIZABETH XXX H. WATTS | | | 2. DATE OF DEATH
MONTH DAY YEAR HOUR
12 12 84 9:00 P.M. | | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
SEPT 28, 1885 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
99 YRS. | | 7. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
INDIANA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. CITY OR TOWN OF DEATH
WHEATON | | 10. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH PLACE, GIVE STREET ADDRESS)
University Convalescent Nursing Home | | 11. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | |
| 12a. STATE
MARYLAND | | 12b. COUNTY
PR. GEORGES | | 12c. CITY OR TOWN
ADELPHI | |
| 13a. FATHER'S NAME
FIRST MIDDLE LAST
ALBERT HEATHER | | 13b. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ANNIE HUME | | | |
| 14a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 14b. SOCIAL SECURITY NO. | | 15. INFORMANT
ADDRESS
HELEN FREEMAN SAME AS 13 DAUGHTER | |
| 16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CVA
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | |
| 17a. DATE OF OPERATION | | 17b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 17c. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 18b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 18c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 19a. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 19b. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 19c. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 20. I certify that (1) (this hospital) attended the deceased from 11/8/82 , to 12/12 , 19 84 , that (1) we last saw the deceased alive on 12/12 , 19 84 , and that in (my) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | |
| 21a. SIGNATURE
Myron L. Lenkin | | | | 21b. DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22a. PHYSICIAN'S NAME (TYPE OR PRINT)
MYRON L. LENKIN | | | | 22b. ADDRESS
SILVER SPRING MONT MD. | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12/18/84 | | 23c. NAME OF CEMETERY OR CREMATORY
CARMEL CEMETERY | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS | | 24b. ADDRESS
500 UNIVERSITY BOULEVARD WEST, SILVER SPRING, MD. | | 25a. DATE REC'D. BY REGISTRAR
DEC 17 1984 | |
| 25b. REGISTRAR'S SIGNATURE
G. Davidson | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 3 4 2 3 3 | | | |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
JEAN WEINER | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12 23 84 | | 2b. HOUR
12²⁵ A.M. | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
4 11 07 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
77 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
RUSSIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
POTOMAC (Rockville) | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
10204 Colebrook Ave, Potomac | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Florida | | 13b. COUNTY
Broward | | 13c. CITY OR TOWN
Ft. Lauderdale | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
NATHAN SEPIEGELMAN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
ESTHER DATZ | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | |
| 16b. SOCIAL SECURITY NO.
107-30-6252 | | 17. INFORMANT ADDRESS
PENNY HELTZER 10204 Colebrook Ave, Potomac, Md | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hepatic failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Metastatic carcinoma
DUE TO, OR AS A CONSEQUENCE OF
(c) Carcinoma of the colon | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
one month
two years
two years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION
10/25/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Carcinoma of the colon | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from November 13, 19 84 , to December 23, 19 84 , that (2) (we) lost saw the deceased alive on 12/14 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (b) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Carol W. Garvey MD | | | | DEGREE
M.D. | | 22c. DATE SIGNED
12/23/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CAROL W. GARVEY MD | | | | 22e. ADDRESS
11510 OLD GEORGETOWN ROAD, ROCKVILLE, MARYLAND, 20852 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
12-24-84 | | 23c. NAME OF CEMETERY OR CREMATORY
SHARON GDNS. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
VALHALLA, N.Y. | |
| 24a. DAN-BANSKY-GOLDBERG MEM. CHP. INC
1170 ROCKVILLE PK. ROCKVILLE MD. | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
DEC 27 1984 Julia Davidson-Randall | | | |

CHIEF



DEC 23 1952

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. 3 4 2 3 4 | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST
IDA | | MIDDLE
G. | | LAST
WEISS | | 2a. DATE OF DEATH MONTH DAY YEAR 12-31-84 2b. HOUR 5 ¹⁵ PM | |
| 3 SEX Female | | 4 RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 11, 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | |
| 10 CITY OR TOWN OF DEATH Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hebrew Home of Greater Washington | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse | | 12b. KIND OF BUSINESS OR INDUSTRY Doctor's Office | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Rockville | |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 6121 Montrose Rd. | | 13f. ZIP CODE 20852 | | | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Jacob Galenski | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Hannah Berman | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A | | 16c. 055 38 7591 | |
| 17 INFORMANT Mark Weiss | | ADDRESS 8811 Brierly Rd., Chevy Chase, Md. | | 20815 | | | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrhythmia
DUE TO, OR AS A CONSEQUENCE OF (b) Terminal Cachexia
DUE TO, OR AS A CONSEQUENCE OF (c) Multi-infarct dementia with depression
Approximate interval between onset and death: less than 1 hr, less than 2 wks | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. Atherosclerotic heart disease with atrial fibrillation | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from 8/10/84 to 12/31/84, that (2) we lost saw the deceased alive on 12/31/84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.) | | | | | | | | | |
| 22b. SIGNATURE Stanley Cutler, MD | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 12/31/84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) STANLEY CUTLER | | 22e. ADDRESS 6121 MONTROSE ROAD ROCKVILLE, MARYLAND 20852 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE Jan. 2, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY Judean Mem. Gdns. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Olney, Maryland | | | |
| 24 FUNERAL DIRECTOR Ives-Pearson Funeral Homes Falls Church, Va. 22046 | | 25a. DATE REC'D. BY REGISTRAR JAN 8 1985 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | | |

BP



100 8000 2000 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 3 4 2 3 5
REG. NO. | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <u>Nina Wennerberg</u> | | | | 2a. DATE OF DEATH MONTH <u>12</u> DAY <u>9</u> YEAR <u>84</u> | | | |
| 3. SEX <u>Female</u> | | 4. RACE <u>White</u> | | 5. DATE OF BIRTH MONTH <u>3</u> DAY <u>16</u> YEAR <u>97</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>87</u> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Minnesota</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD. | |
| 10. CITY OR TOWN OF DEATH <u>Olney Maryland</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Sharon Nursing Home</u> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>HOME MAKER</u> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <u>Md. PR. GEO</u> | | 13b. CITY OR TOWN <u>Laurel</u> | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE <u>10300 Gorman Road</u> | |
| 14. FATHER'S NAME FIRST <u>EDWARD</u> MIDDLE LAST <u>STONE</u> | | 15. MOTHER'S MAIDEN NAME FIRST <u>Stone</u> MIDDLE LAST <u>HENDERSON</u> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u> | | 16b. SOCIAL SECURITY NO. <u>23 36 0646 D</u> | | 17. INFORMANT ADDRESS <u>Floyd Wennerberg 10300 Gorman Road Laurel Md.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardio-pulmonary collapse</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral vascular accident</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>2 Hours</u>
<u>7 days</u>
<u>many years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<u>URI with fever</u> | | | | | | | |
| 19a. DATE OF OPERATION <u>—</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u> | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <u>—</u> | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>—</u> | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 14</u> , 19 <u>82</u> , to <u>Dec 9</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>Dec 2</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Albert S. Whiting</u> M.D. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED <u>Dec 9, 1984</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Albert S. Whiting</u> | | | | 22e. ADDRESS <u>3933 Pitcairn Pl Laurel Md</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL <u>Burial.</u> | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Bladensburg Rd. P. G. Md.</u> | |
| 24. FUNERAL DIRECTOR <u>Takoma Funeral Home.</u> | | | | 25. DATE REC'D. BY REGISTRAR <u>DEC 12 1984</u> REGISTRAR'S SIGNATURE <u>Julian Henderson</u> | | | |

27

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|
| 1. FOR
STATE
REGISTRAR | | 3 4 2 3 6 | | REG. NO. | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
EDITH A. WEST | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Dec. 5, 1984 | | | 2b. HOUR
11:05
A. M. | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 17, 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73
YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASHINGTON, DC | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
9402 Riley Place | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. STREET ADDRESS
9402 Riley Place 20910 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ERNEST ADMIRE | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
LOTTIE NABORS | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
577-07-9233 | | 17. INFORMANT
JAMES WEST | | | | ADDRESS
SAME AS 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial disease
DUE TO, OR AS A CONSEQUENCE OF
(b) hypertensive heart disease.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None | | | | | | | | | |
| 19a. DATE OF OPERATION
None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
None | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (I) (the health officer) attended the deceased from 2/26/76 19 84 , to 12/5 19 84 , that (I) 206 lost saw the deceased alive on 11/20 19 84 , and that in (my) xx opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death. | | | | | | | | | |
| 22a. SIGNATURE
John S. Rogers, M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22b. DATE SIGNED
12/5/84 | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)
John S. Rogers, M.D. | | | | 22d. ADDRESS
1919 Seminary Road, Silver Spring, MD 20910 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
CREMATION | | 23b. DATE
12/6/84 | | 23c. NAME OF CEMETERY OR CREMATORY
METROPOLITAN CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ALEXANDRIA VIRGINIA | | | |
| 24. FUNERAL DIRECTOR FRANCIS J. COLLINS
NAME ADDRESS
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | 25. DATE REC'D. BY REGISTRAR DEC 10 1984
BY REGISTRAR'S SIGNATURE John Davidson | | | | | |

John B. Rogers, M.D.

1919 Seminary Road, Silver Spring, MD 20910

12/2/84

x

xxx
xxxxx

11/20

84

2/26/76

xx

12/2

84

xx

None

None

hypertensive heart disease.
acute myocardial disease

Maryland
Montgomery Silver Spring
9402 Riley Place
Silver Spring
9402 Riley Place
Homemaker

Montgomery County

Female

White

Dec. 17, 1910

73

WEST

EDITH

Dec. 2, 1984

11:05
A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death. This certificate should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 above any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 34237 | |
|---|--|--|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) JEANNE C. WIEDERHORN | | | | 2a. DATE OF DEATH MONTH 12 DAY 01 YEAR 84 2b. HOUR 7 AM PM | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH June DAY 1 YEAR 1965 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. AGE (IN YEARS LAST BIRTHDAY) 19 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student | | 12b. KIND OF BUSINESS OR INDUSTRY ----- | | | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Bethesda | |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 5718 Huntington Pkwy. 20814 | | | |
| 14. FATHER'S NAME FIRST Sheldon MIDDLE LAST Wiederhorn | | 15. MOTHER'S MAIDEN NAME FIRST Nancy MIDDLE Irene LAST Wanderman | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 577-04-4646 | | 17. INFORMANT Sheldon Wiederhorn; Bethesda, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Brain Tumor
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mos |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) this hospital) attended the deceased from 11/30 19 84 , to 12/1 19 84 , that (1) (we) last saw the deceased alive on 11/30 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Fred A. Gill, MD DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/1/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) FRED A. GILL, MD | | 22e. ADDRESS 4743 Bradley Blvd, Chevy Chase | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12-3-1984 | | 23c. NAME OF CEMETERY OR CREMATORY Judean Mem. Gardens | |
| 23d. LOCATION CITY OR TOWN Olney COUNTY Maryland STATE | | 24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike ADDRESS Rockville, Md. | | | |

BP

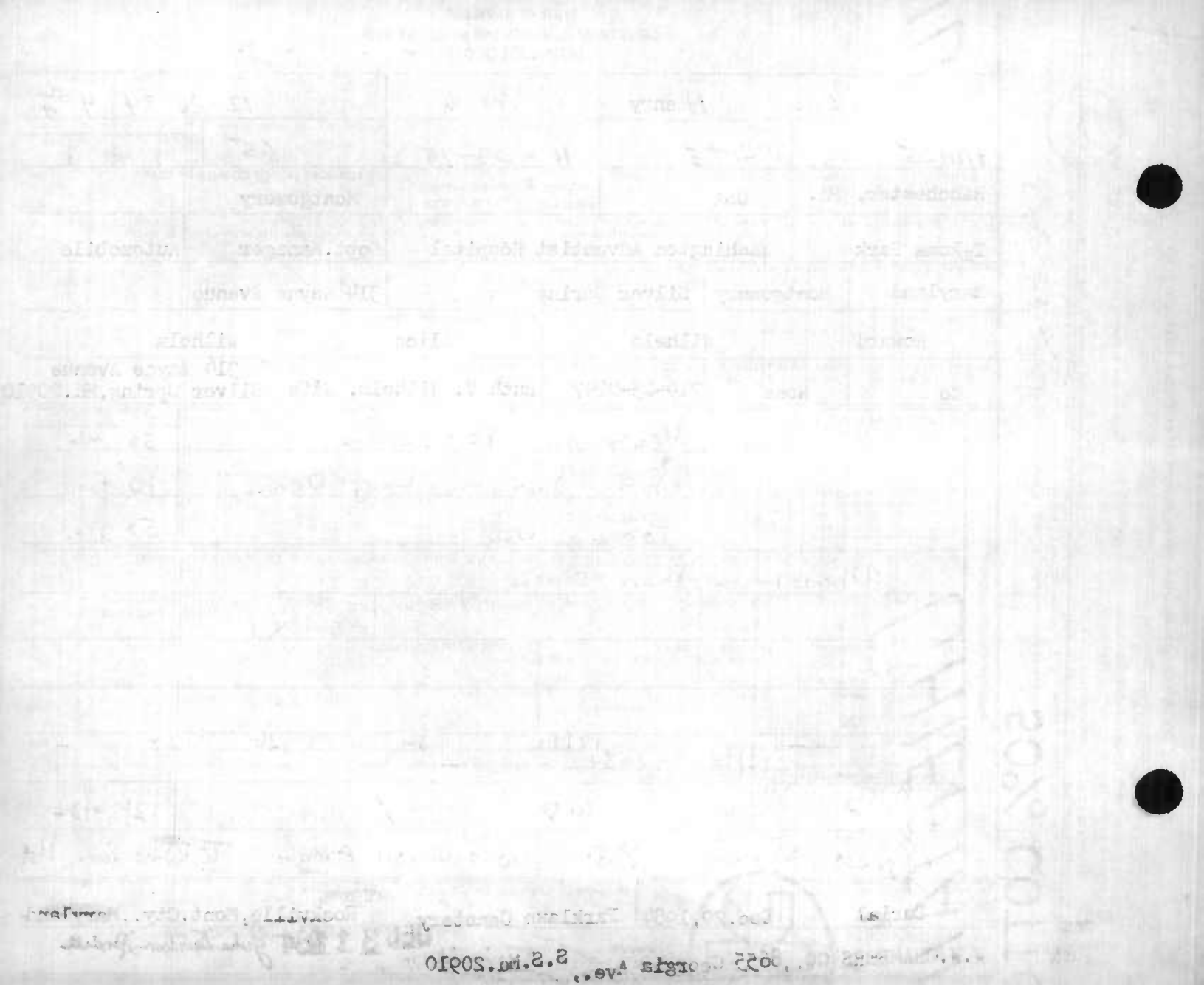
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 4 2 3 8
REG. NO.

| | | | | | | | |
|---|--|---|--|--|-----------------------------------|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2b. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| PAUL Henry Wilhelm | | 12-26-84 | | 4 58 PM | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| MALE | WHITE | 11-23-19 | 65 YRS | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Manchester, PA. | USA | | Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Takoma Park | Washington Adventist Hospital | | Dept. Manager | | Automobile | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS | | | |
| Maryland | Montgomery | Silver Spring | | 314 Wayne Avenue 20910 | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | |
| Howard Wilhelm | | Alice Wilhelm | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| No | | 219-05-0247 | | 314 Wayne Avenue | | | |
| | | None | | Ruth V. Wilhelm, Wife Silver Spring, Md. 20910 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Ventricular Tachycardia | | | | | | | 30 min. |
| DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Obstructive Lung Disease | | | | | | | 10 yrs |
| DUE TO, OR AS A CONSEQUENCE OF (c) Tobacco Use | | | | | | | 50 yrs. |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Atherosclerotic Heart Disease | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 12/22, 1984, to 12/26, 1984, that (I) (we) last saw the deceased alive on 12/25, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | DEGREE | | 22c. DATE SIGNED | |
| Alfred Munzer M.D. | | | | M.D. | | 12/26/84 | |
| 22d. ADDRESS | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| 7600 Carroll Avenue Takoma Park, Md | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | Dec. 29, 1984 | | Parklawn Cemetery | | Rockville, Mont. Cty., Maryland | |
| 24. FUNERAL DIRECTOR | | | | 25. SIGNATURE OF REGISTRAR | | | |
| W.W. CHAMBERS CO., 8655 Georgia Ave., S.S. Md. 20910 | | | | J. Davidson | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 74 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 3 4 2 3 9
REG. NO. | |
|--|--|---|--|---|--|--|--|---|--|--|--|
| 1- STATE REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) JAMES EDWARD WILLIAMS | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR Dec 4 1984 | | 2b. HOUR 3:30 PM | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH
MONTH DAY YEAR May 30 1924 | | 6. AGE (IN YEARS LAST DAY) 60 YRS. | | 7. IF UNDER 1 YR. MONTHS DAYS | | 7c. DATE PRONOUNCED DEAD Dec 4 1984 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | | | | |
| 10. CITY OR TOWN OF DEATH
Tak Park | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Wash. Adventist Hosp | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Laundry Presser | | 12b. KIND OF BUSINESS OR INDUSTRY
Jim Dannels Cleaners | |
| 13a. STATE DC | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Washington | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1205 Gwyneth St. NW | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frank Rorie | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Annie Lindsey | | | | 16. INFORMANT 1424 Clifton Street, NW; #7 Florence F. Williams (wife) Wash. DC | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO.
218-28-8417 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Soubt myocardial Dis
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
None | | | | | | | | | | | |
| 19a. DATE OF OPERATION
None | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE John S. Rogers M.D. | | | | TITLE (SPECIFY)
Dep silver Spring, Maryland | | | | DATE Dec 4 1984 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D. | | | | ADDRESS 1919 Seminary Road, | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/11/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Maryland National Memorial Park | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Laurel, P.G.CO., Maryland | | | |
| 24. FUNERAL DIRECTOR LATNEY's Funeral Home
3831 Georgia Ave. NW; Wash. DC 20011 | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 18 1984 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | |

RECEIVED

NOV 20 1964



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate may be retained by the hospital or attending physician.

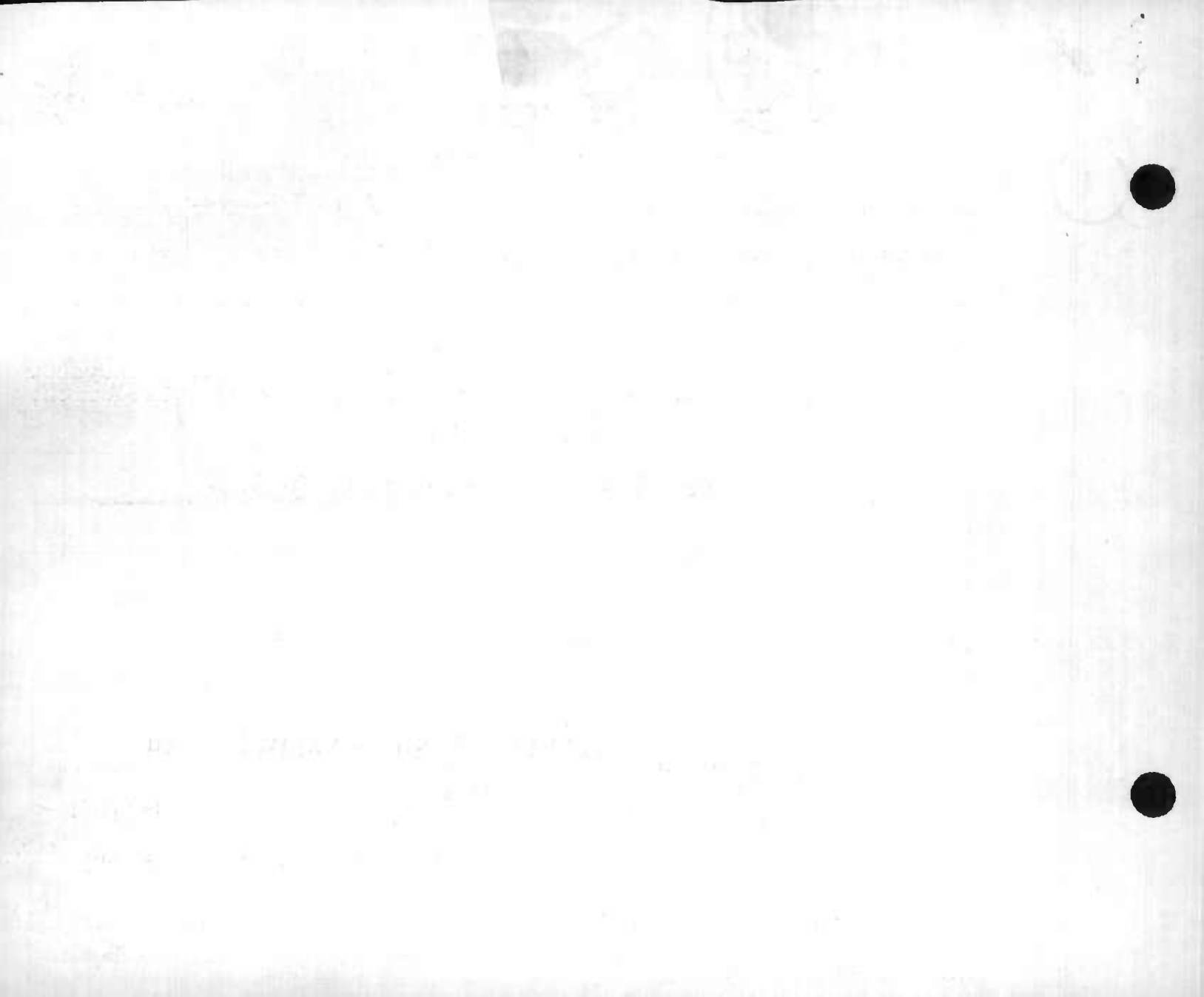
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 above only injury, or other traumatic event, the medical examiner must be notified of the cause.

DHMH - 16 50M 4/83
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 3 4 2 4 0
REG. NO. | |
|--|--|--|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT)
First: <u>ORAN</u> Middle: <u>Hawley</u> Last: <u>Williams</u> | | | | 2a. DATE OF DEATH
MONTH: <u>12</u> DAY: <u>14</u> YEAR: <u>84</u> | | | 2b. HOUR
<u>12⁴⁵</u> P.M. | | |
| 3. SEX
<u>Female</u> | | 4. RACE
<u>Caucasian</u> | | 5. DATE OF BIRTH
MONTH: <u>August</u> DAY: <u>8</u> YEAR: <u>1910</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>74</u> YRS. | | 7. IF UNDER 1 YEAR
MONTHS: <u></u> DAYS: <u></u> | | 8. IF UNDER 24 HRS
HOURS: <u></u> MIN: <u></u> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>Washington</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>United States</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>MONTGOMERY County MD.</u> | | | | | |
| 10. CITY OR TOWN OF DEATH
<u>Bethesda</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>SUBURBAN Hospital</u> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Economist</u> | | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>U.S. Gov't</u> | | |
| 13a. STATE
<u>Maryland</u> | | | | 13b. CITY OR TOWN
<u>Montgomery Chevy Chase</u> | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE
<u>4816 Cumberland Avenue 20815</u> | | | |
| 14. FATHER'S NAME
First: <u>Frank</u> Middle: <u>Lawrence</u> Last: <u>Hawley</u> | | | | 15. MOTHER'S MAIDEN NAME
First: <u>Anita</u> Middle: <u>Margaret</u> Last: <u>McKay</u> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
<u>No</u> | | | | 16b. SOCIAL SECURITY NO.
<u>579-58-1855</u> | | 17. INFORMANT (Son) ADDRESS
<u>4310 Buckeystown Randall B. Williams, Pike, Frederick, MD</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory arrest.</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>MD</u> | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Ca. of Breast, Metastatic Disease</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u></u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<u>P.M. 19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/12/84</u> , 19 <u>84</u> , to <u>12/14/84</u> , 19 <u>84</u> , that (I) (we) lost
saw the deceased alive on <u>12/14/84</u> , 19 <u></u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Hamid Montakhab</u> | | | | DEGREE <u>M.D.</u>
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
<u>12/14/84</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>HAMID MONTAKHAB, MD</u> | | | | 22e. ADDRESS
<u>6111 Executive Blvd, Rockville, MD 20852</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Cremation</u> | | | | 23b. DATE
<u>15, 1984</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Metropolitan Crematory</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Alexandria Virginia</u> | | | |
| 24. FUNERAL DIRECTOR
NAME <u>Robert A. Pumphrey Funeral Homes</u>
P.A. Bethesda, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR
<u>DEC 18 1984</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Davidson-Randall</u> | | | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified of age.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 34241 | |
|---|--|---|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ADRIAN E. WILLIS | | | | | 2a. DATE OF DEATH
MONTH 12 DAY 2 YEAR 84 | | | 7b. HOUR
915/P
M | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH 7 DAY 26 YEAR 95 | | 6. AGE (IN YEARS LAST BIRTHDAY)
89 YRS. | | IF UNDER 1 YEAR
MONTHS 8 DAYS 15 | | IF UNDER 24 HRS.
HOURS 9 MIN. 15 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N. CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
WHEATON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIV. CONTR. + NURSING HOME | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
PRINTER | | 12b. KIND OF BUSINESS OR INDUSTRY
DEPT. ENGRAVING | | | |
| 13a. STATE
MD | | | 13b. COUNTY
MONT | | 13c. CITY OR TOWN
SILVER SP | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
10703 ORDWAY DR. 20901 | | |
| 14. FATHER'S NAME
FIRST ELIJAH MIDDLE WILLIS LAST ADAMS | | | | | 15. MOTHER'S MAIDEN NAME
FIRST CHESTINE MIDDLE DAUGHTER LAST ADAMS | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO.
167-01-5447 | | 17. INFORMANT
CATHERINE W. GOTTLIED, ANNAPOLIS, MD. 21403 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Cerebral ischemia
DUE TO, OR AS A CONSEQUENCE OF
(b) Hypertensive arteriosclerotic cardio-vascular disease 20 yrs
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 mo | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 11, 1987 to Dec. 2, 1984 , that the (we) last saw the deceased alive on Dec. 2, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Raymond Bradshaw Jr.
22b. PHYSICIAN'S NAME (TYPE OR PRINT)
Raymond Bradshaw | | | | DEGREE
M.D.
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
Dec. 2, 1984 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
12/6/84 | | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
SILVER SPRING MONT MD. | | | |
| 24. FUNERAL DIRECTOR
NAME FRANCIS J. COLLINS
ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 6 1984 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Rendall | | | |

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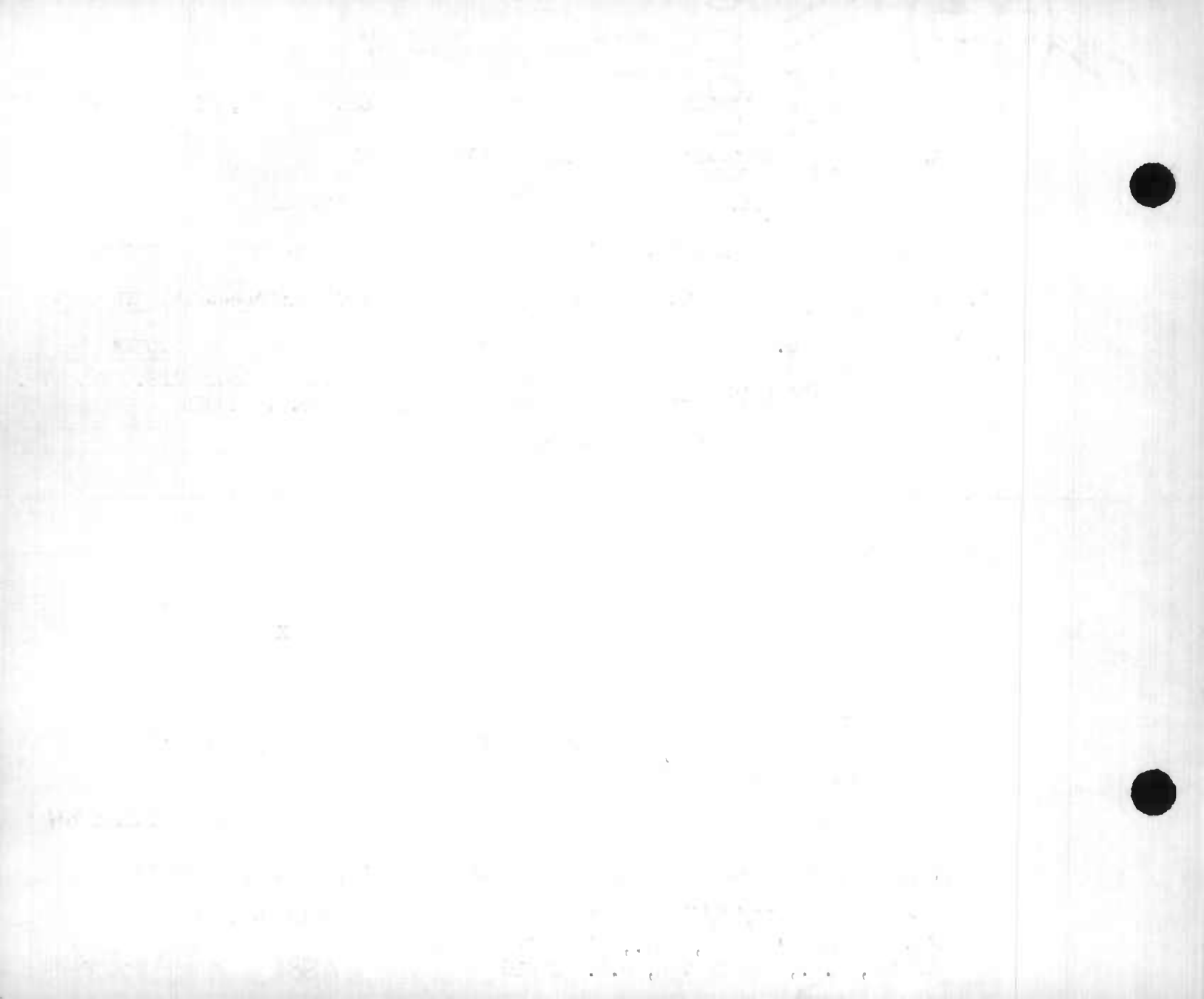
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 34242 | | | |
|---|--|--|--|---|--|---|---|
| 1. STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
BENTLEY LESLIE WILSON | | | | 2a. DATE OF DEATH MONTH DAY YEAR
DECEMBER 12, 1984 | | 2b. HOUR a m
8:55 a | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR
OCT 3, 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
COLORADO | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA, MD | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL BETHESDA, MD | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED NAVY | | 12b. KIND OF BUSINESS OR INDUSTRY
MILITARY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY
D. C. 13c. CITY OR TOWN
WASHINGTON | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
4000 MASSACHUSETTS AVE 20016 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
ERNEST B. WILSON | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
CORA MARGARET STOVER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
1936-1966 | | 17. INFORMANT ADDRESS
MARGARET BARTON WILSON, 4000 MASS. AVE. N.W.
#1017, WASHINGTON, D.C. 20016 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CANCER ESOPHAGUS</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>NOVEMBER 16, 1984</u> , to <u>DECEMBER 12, 1984</u> , that (I) (we) last saw the deceased alive on <u>DECEMBER 12, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not see the body of the deceased) | | | | | | | |
| 22b. SIGNATURE
<i>William A. Delacey</i> MD | | | | DEGREE
MD | | 22c. DATE SIGNED
12 Dec 84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
WILLIAM A. DELACEY, MD, LT, MC, USNR | | | | 22e. ADDRESS
NAVAL HOSPITAL BETHESDA, MD 20814 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12/14/84 | | 23c. NAME OF CEMETERY OR CREMATORY
ARLINGTON NATIONAL | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ARLINGTON, VA | |
| 24. FUNERAL DIRECTOR
NAME
JOSEPH GAWLER'S SONS, INC., 5130 WISCONSIN AVENUE, N.W., WASHINGTON, D.C. 20016 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 17 1984 | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | |



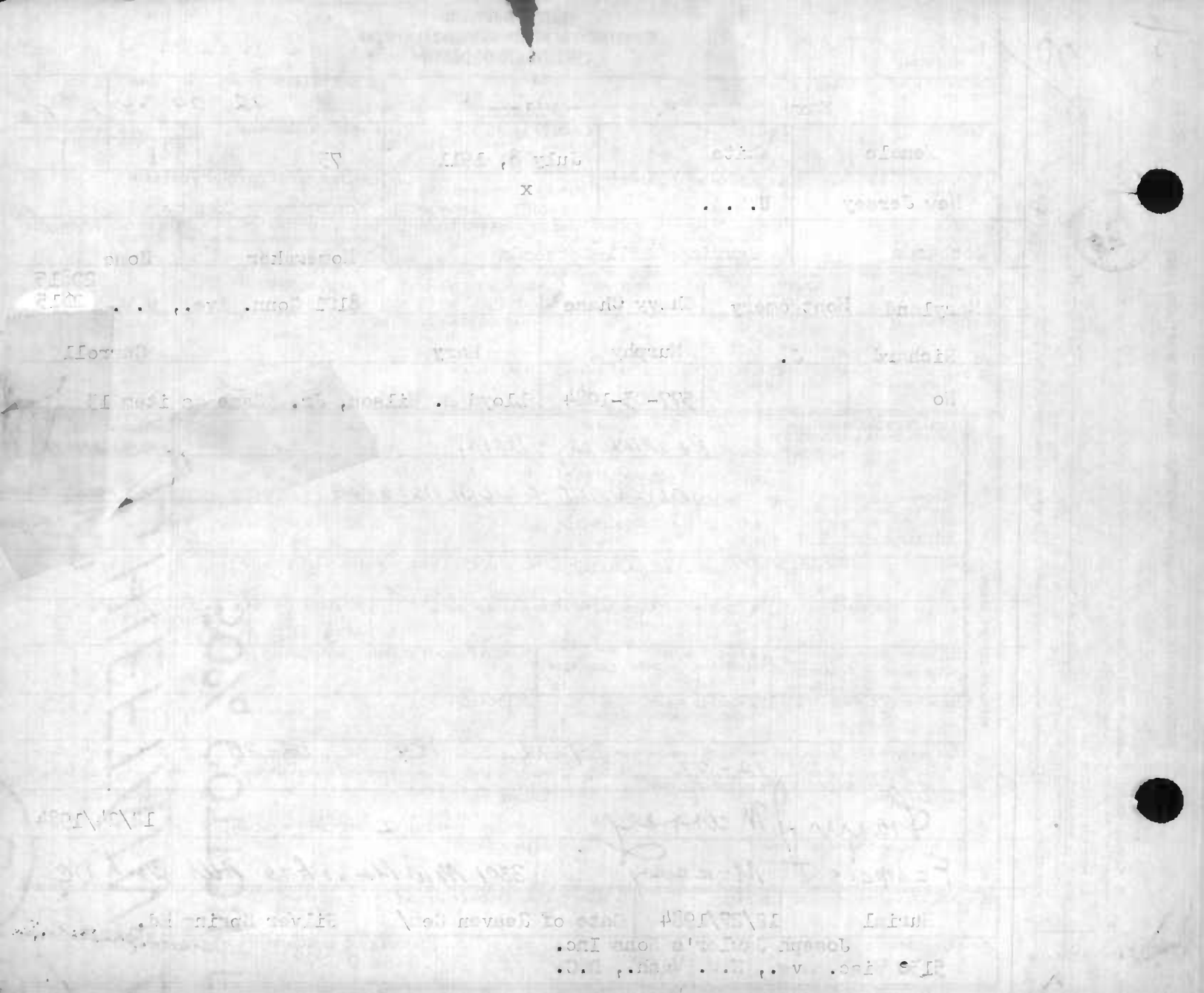
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | 3 4 2 4 3
REG. NO. | | | | | |
|--|--|---|--|---|---|---|----------------------------------|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Mary M. Wilson | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 24 84
2b. HOUR
6 ¹⁰ P.M. | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 8, 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New Jersey | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Carriage Hill-Bethesda | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Chevy Chase | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Richard J. Murphy | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Carroll | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
577-03-1084 | | 17. INFORMANT
ADDRESS
Lloyd B. Wilson, Jr. Same as item 13 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>MALIGNANT GLIOBLASTOMA</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>IMMEDIATE</u>
<u>13 MON.</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-12</u> , 19 <u>84</u> , to <u>12-24</u> , 19 <u>84</u> , that (I) (we) lost
saw the deceased alive on <u>12-22</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Francis J. Murray</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/24/1984 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>FRANCIS J. MURRAY</u> | | | | 22e. ADDRESS
<u>3301 New Mexico Ave NW Wash DC.</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/27/1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cem/ | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring Md. | | | | |
| 24. FUNERAL DIRECTOR
NAME
Joseph Gawler's Sons Inc.
ADDRESS
5130 Wisc. Ave., N.W. Wash., D.C. | | | | 25a. DATE REC'D BY REGISTRAR
DEC 28 1984 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 3 4 2 4 4
REG. NO. | |
|---|--|--|--|---|--|--|---|--|------------------------------|--|--|
| 1. FOR
STATE
REGISTRAR | | | 1. DECEASED NAME
(TYPE OR PRINT)
EDA WISZNIA | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-14-84 | | | 2b. HOUR
7 ³⁰ P.M. | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 15, 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 8. IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE
(COUNTRY)
Poland | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Hebrew Home of Greater Washington | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
6121 Montrose Road 20852 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Nussen Tzvi Bronstein | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unascertainable Unascertainable | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]
No | | | | 16b. SOCIAL SECURITY NO.
491-34-5051 | | 17. INFORMANT
ADDRESS
1810 Blueridge Avenue,
Ethel Kaplan Silver Spring, Maryland 20902 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Recurrent Aspiration Pneumonitis
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
less than 12 hours | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Organic Brain Syndrome, Arteriosclerotic heart disease, Osteoarthritis | | | | | | | | | | | |
| 19a. DATE OF OPERATION
- | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
- | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
- | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/19/84 to 12/14/84, that (I) (we) lost
saw the deceased alive on 12/14/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Stanley Cutler, MD | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
12/15/84 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
STANLEY CUTLER | | | | | | 22e. ADDRESS
6121 MONTROSE RD.
ROCKVILLE MD 20852 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
12/16/1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Mount Lebanon | | | 23d. LOCATION
CITY OR TOWN P.O. BOX STATE
Adelphi, P.O. G. Md. | | | |
| 24. FUNERAL DIRECTOR
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME
232 CARROLL STREET, N. W., WASHINGTON, D. C. | | | | | | | | | | | |
| 25a. DATE REC'D. BY REGISTRAR
DEC 18 1984 | | | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE
John L. ... | | | | | | | | | | | |

(S2 90-1975)

1. The first part of the report is a summary of the work done during the year.

2. The second part is a detailed account of the work done during the year.

3. The third part is a summary of the work done during the year.

4. The fourth part is a summary of the work done during the year.

5. The fifth part is a summary of the work done during the year.

6. The sixth part is a summary of the work done during the year.

7. The seventh part is a summary of the work done during the year.

8. The eighth part is a summary of the work done during the year.

9. The ninth part is a summary of the work done during the year.

10. The tenth part is a summary of the work done during the year.

11. The eleventh part is a summary of the work done during the year.

12. The twelfth part is a summary of the work done during the year.

13. The thirteenth part is a summary of the work done during the year.

14. The fourteenth part is a summary of the work done during the year.

15. The fifteenth part is a summary of the work done during the year.

16. The sixteenth part is a summary of the work done during the year.

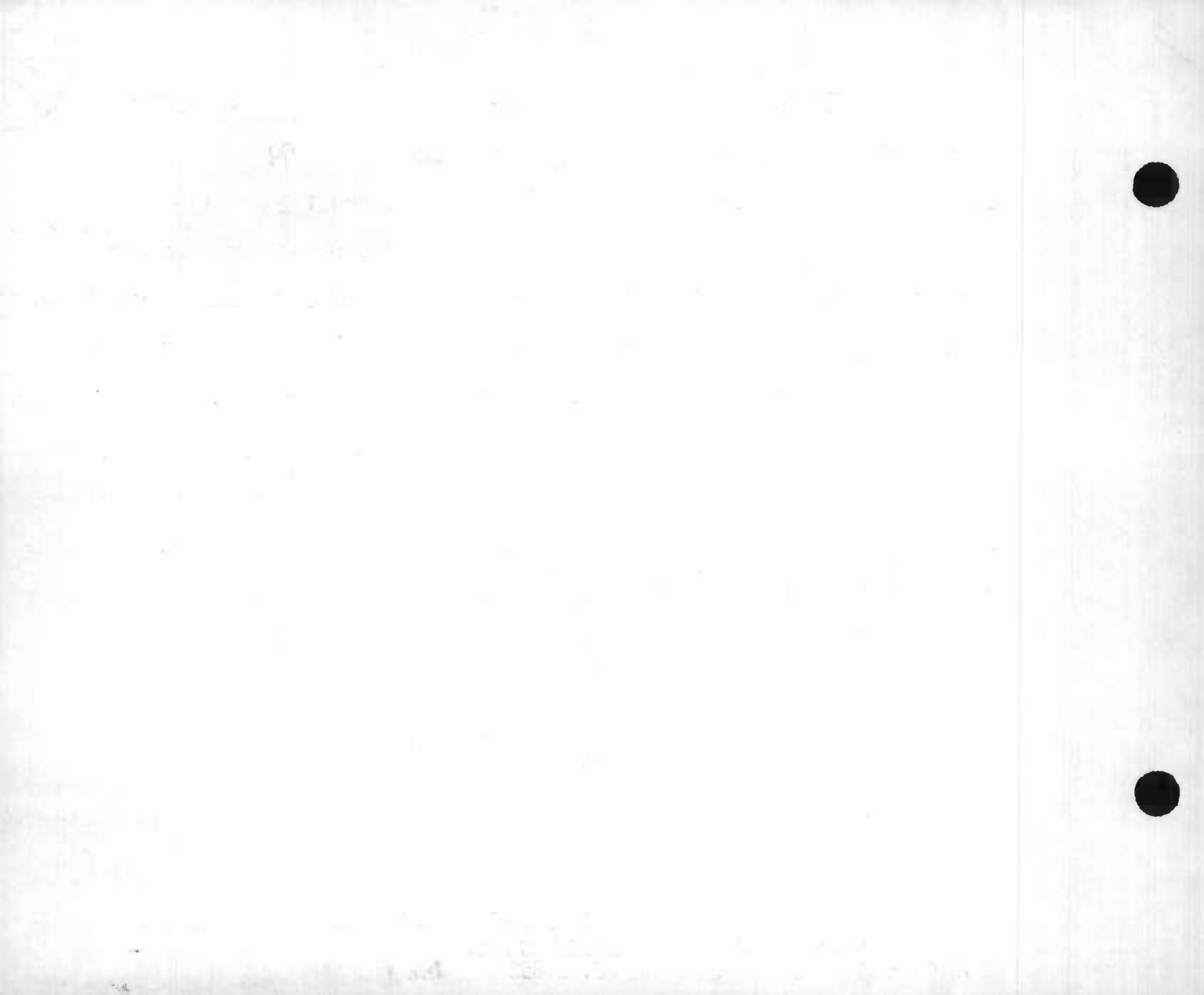
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

15

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 3 4 2 4 5
REG. NO. | | | |
|--|--|--|--|---|---|--|---|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | 1. DECEASED NAME
(TYPE OR PRINT) IDA GORDON Wolf | | | | 2a. DATE OF DEATH
MONTH DAY YEAR 12-06-84 | | | 2b. HOUR
10⁰⁰ A.M. | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR 12-05-05 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Russia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Payroll Officer | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Gov't. Fed. Home Loan | | | | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
8201 16th Street, #1203 (20910) | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Ellis Stearman | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Miriam Herman | | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | | | |
| 16b. SOCIAL SECURITY NO.
217-44-0422 | | | | 17. INFORMANT
Abraham Wolf; 8201 16th St., #1203; Silver Sp., Maryland 20910 | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) POLYCYTHEMIA VERA (END STAGE)
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1971 | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
VASCULITIS, DIABETES | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 84 to 19 84 , that (I) (we) lost
saw the deceased alive on 12/6 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22b. SIGNATURE
John I. Rheingold M.D. | | 22c. DATE SIGNED
12/6/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JACK I. RHEINGOLD | | | 22e. ADDRESS
2201 L ST. N.W. WASH. D.C. | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
12/9/84 | | 23c. NAME OF CEMETERY OR CREMATORY
B'Nai Israel Cong. Cemetery; Oxon Hill; P.G.; Maryland | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | | |
| 24. FUNERAL DIRECTOR
NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Rosen | |
| 1170 Rockville Pike; Rockville, Md. 20852 | | | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

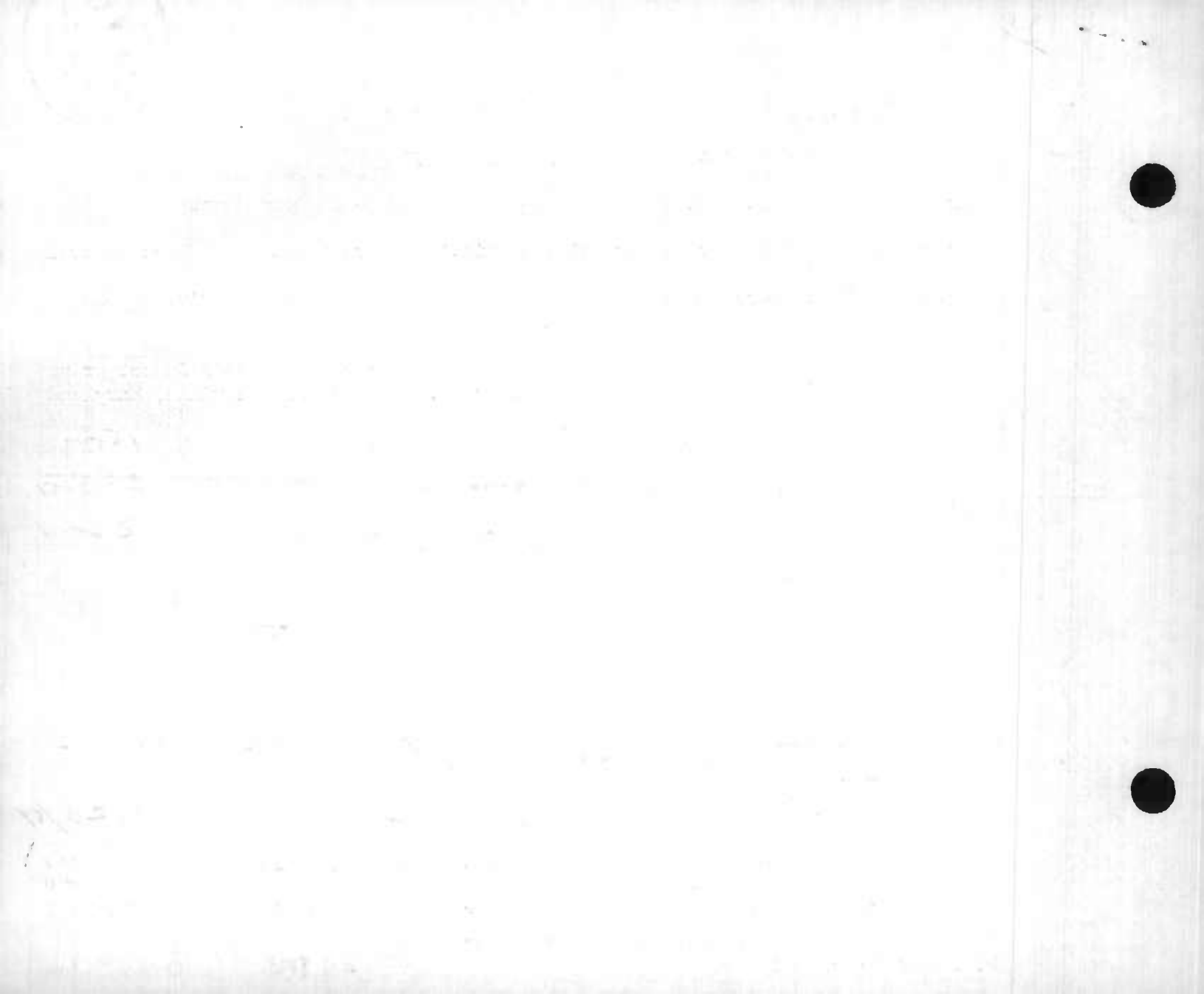


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be completed above.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH 84 | | | | | | | | | | REG. NO. 34246 | |
|--|--|--|--|--|--|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) <u>Samuel E WOMACK</u> | | | | | | 2a. DATE OF DEATH
MONTH <u>Dec.</u> DAY <u>22</u> YEAR <u>1984</u> | | 2b. HOUR <u>22:30</u> | |
| 3. SEX
<u>Male</u> | | 4. RACE
<u>Caucasian</u> | | 5. DATE OF BIRTH
MONTH <u>12</u> DAY <u>13</u> YEAR <u>05</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>79</u> YRS. | | IF UNDER 1 YEAR
MONTHS <u></u> DAYS <u></u> | | IF UNDER 24 HRS.
HOURS <u></u> MIN. <u></u> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>Virginia</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>United States</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Montgomery County</u> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
<u>Rockville</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Shady Grove Adventist Hospital</u> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>President</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>Pest Control</u> | | | |
| 13a. STATE
<u>Maryland</u> | | | | 13b. COUNTY
<u>Montgomery</u> | | 13c. CITY OR TOWN
<u>Rockville</u> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<u>13301 Valley Drive 20850</u> | |
| 14. FATHER'S NAME
FIRST <u>Charlie</u> MIDDLE <u>Watson</u> LAST <u>Womack</u> | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST <u>Sally</u> MIDDLE <u></u> LAST <u>Hutchin</u> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<u>No</u> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<u>N/A</u> | | 17. INFORMANT (Daughter)
<u>Barbara M. Burkinshaw, Rockville, Maryland</u> | | ADDRESS <u>9609 Sunset Drive</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Cardiac Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Recent Subendocardial infarction</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery disease</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>15 min.</u>
<u>2-3 hr.</u>
<u>2 years</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<u>P.M.</u> <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1976</u> to <u>12</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>12/20</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>R. A. Pumphrey</u> | | | | DEGREE <u>MD</u>
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
<u>12/23/84</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>R. A. Pumphrey</u> | | | | 22e. ADDRESS
<u>12105 Oakcrest Rd Gaithersburg</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) <u>Burial</u> | | 23b. DATE <u>December 27, 1984</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Parklawn Memorial Park</u> | | 23d. LOCATION
CITY OR TOWN <u>Rockville</u> COUNTY <u>Maryland</u> STATE <u></u> | | | | | |
| 24. FUNERAL DIRECTOR
NAME <u>Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland</u> ADDRESS <u></u> | | | | | | 25a. DATE REC'D. BY REGISTRAR
<u>DEC 24 1984</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Lila Burkinshaw</u> | | | |



#5,15, FilmG598 12/21/84 kam

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 4 2 4 7
REG. NO.1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Tsui Y. Wong | | | 2a. DATE OF DEATH
MONTH 12 DAY 9 YEAR 84 | | | 2b. HOUR 1346 P M | | | | | |
| 3. SEX
Female | | 4. RACE
Oriental | | 5. DATE OF BIRTH
MONTH 6 DAY 20 YEAR 17 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
China | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Seed Specialist | | 12b. KIND OF BUSINESS OR INDUSTRY
Univ. of Md. | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE
Heritage House 20851 | | |
| 14. FATHER'S NAME
FIRST Siu MIDDLE Yip LAST Wong | | | | 15. MOTHER'S MAIDEN NAME
FIRST Sau MIDDLE Hing LAST Hald | | | | 15. ADDRESS
Rockv. Md. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
N/A | | 16b. SOCIAL SECURITY NO.
N/A | | 17. INFORMANT
May Lam -sister- 13117 Beaver Terr. 20853 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) sign this body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
CHANCHEN | | | 22c. ADDRESS
11800 N.H. Ave., Silver Spring, Md. | | | 22d. DATE
Dec. 14, 1984 | | 22e. NAME OF CEMETERY OR CREMATORY
Lee's Crematory | | | |
| 22f. LOCATION
Wash. DC | | | 22g. DATE REC'D BY REGISTRAR
DEC 13 1984 | | | 22h. REGISTRAR'S SIGNATURE
Julia Spitzer | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE OF)
Cremation | | | 23b. DATE
Dec. 14, 1984 | | | 23c. NAME OF CEMETERY OR CREMATORY
Lee's Crematory | | | 23d. LOCATION
Wash. DC | | |
| 24. FUNERAL DIRECTOR
NAME
Hines/Rinaldi Funeral Home | | | ADDRESS
11800 N.H. Ave., Silver Spring, Md. | | | 25a. DATE REC'D BY REGISTRAR
DEC 13 1984 | | | | | |

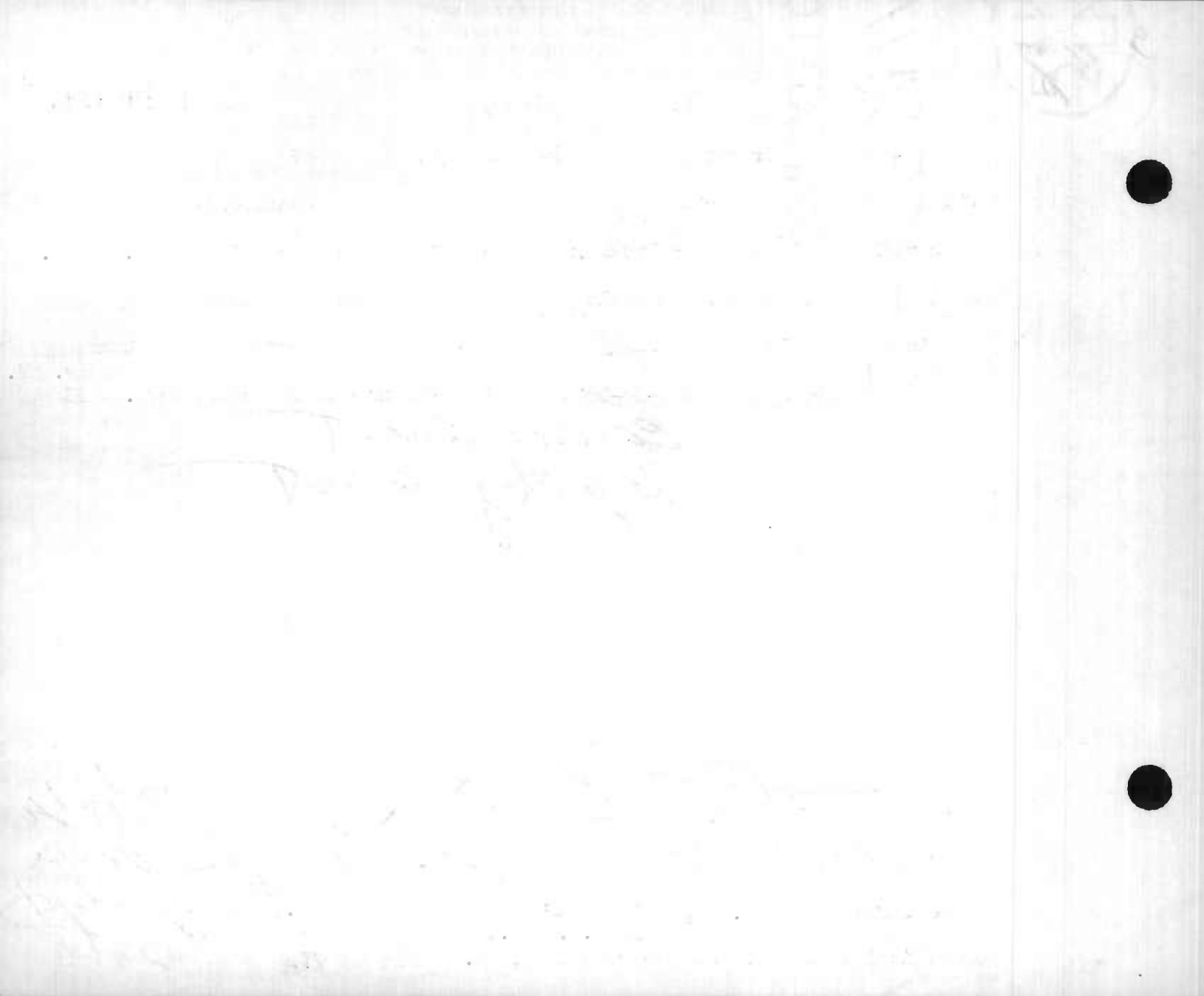
17
15
35
151
1
2
9

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified advance.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

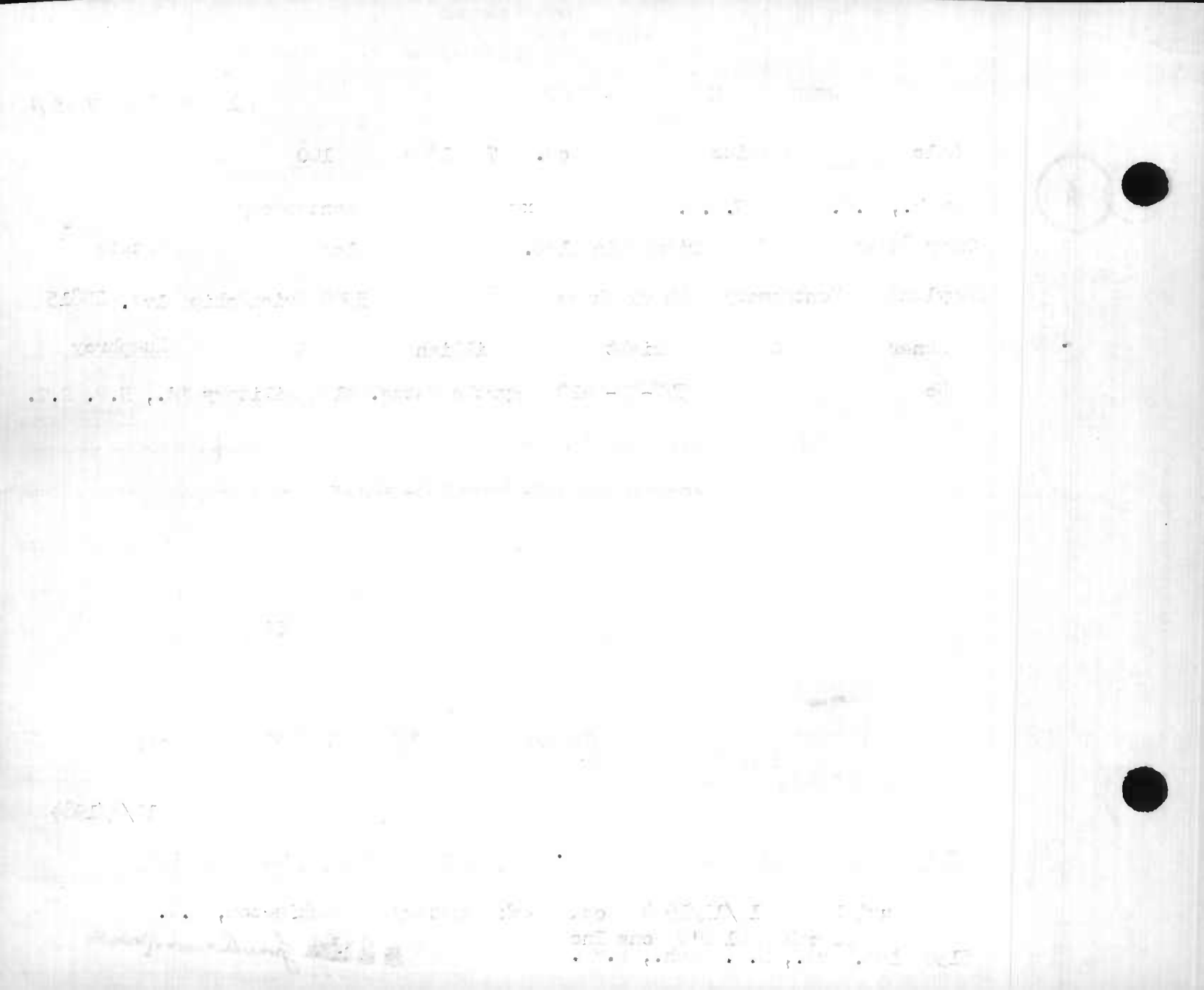
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 3 4 2 4 8
REG. NO. | | | | | | | |
| I. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
JOHN H WRIGHT | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12 8 84 | | 2b. HOUR
7:15 AM | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
Nov. 7 1884 | | 6. AGE (IN YEARS LAST BIRTHDAY)
100 YRS. | | 7. IF UNDER 1 YEAR IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash., D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Chevy Chase | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5500 Friendship Blvd. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Sales | | 12b. KIND OF BUSINESS OR INDUSTRY
Real Estate | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Chevy Chase | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
5500 Friendship Blvd. 20815 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Abner O Wright | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Lillian E Humphrey | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
577-09-5420 | | 17. INFORMANT ADDRESS
Myrtle Yates. 4132 Military Rd., N.W. D.C. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Atherosclerotic Heart Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 30</u> , 19 <u>84</u> , to <u>Dec 8</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>Dec 7</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Philip Kantoff MD</u>
THE PHYSICIAN'S NAME (TYPE OR PRINT) | | | | DEGREE
MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12/8/1984 | |
| 22e. ADDRESS
<u>2127 California St NW DC</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/11/1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Rock Creek Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D.C. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Joseph Gawler's Sons Inc
5130 Wisc. Ave., N.W. Wash., D.C. | | | | 25a. DATE RECEIVED BY REGISTRAR
DEC 8 1984 | | 25b. REGISTRAR'S SIGNATURE
<u>John Davidson</u> | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical investigation conducted.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|
| 1. FOR
STATE
REGISTRAR | | 3 4 2 4 9
REG. NO. | | 1. DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE OF DEATH
MONTH DAY YEAR | | 2b. HOUR | |
| Pei | | Chih | | Wu | | November 27, 1984 | | 1:40A.M. | |
| 3. SEX
Female | | 4. RACE
Chinese | | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb. 29, 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY)
89 YRS. | | 7. UNDER 1 YEAR
MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
China | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | | |
| 13a. STATE
Maryland | | 13b. CITY OR TOWN
P.G. | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
10903 Sutton Drive 20772 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Unknown | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO.
218-66-4811 | | 17. INFORMANT
Mr. David Wu | | ADDRESS
Address Same as No# 13e. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Myocardial infarction</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>ASH & AF</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.
① Multiple Embolization ② generalized atherosclerosis ③ CBS | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Gangrene of Lower Extremity | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21i. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/15</u> , 19 <u>84</u> , to <u>11/27</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>11/27</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Bernadette C.F. Soong, M.D. | | | | DEGREE
M.D. | | 22c. DATE SIGNED
11/27/84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BERNADETTE C.F. SOONG, M.D. | | | | 22e. ADDRESS
1106 Spring Street, Silver Spring Md 20910 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Dec. 1, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood P.G. Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME
F. Gasch's Sons F.H. P.A. Hyattsville, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
DEC 3 1984 John Smith, Registrar | | | | | |

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 3 4 2 5 0 | | | | | | | | | | | | | | | | | |
|--|--|----------|--|------------------------------------|--------|---|--------------|------------------|--------------------------------------|--------------------|-------------------------------------|---|--|------------------|---|-------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST KIMI | | MIDDLE | | LAST YOSHINO | | 2a. DATE KNOWN OF DEATH
ESTIMATED | | 2b. DATE OF DEATH
MONTH DAY YEAR | | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR | | 2d. HOUR | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH
MONTH DAY YEAR | | 6. AGE (IN YEARS)
(1.8 BIRTHDAY) | | 7. IF UNDER 1 YR | | 7. IF UNDER 24 HRS | | 8. MARRIED | | 8. NEVER MARRIED | | 8. DIVORCED | |
| Female | | Oriental | | June 11 1894 | | 90 | | YRS. | | MONTHS DAYS | | HOURS MIN. | | Dec 28 1984 | | M | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED | | | 8. NEVER MARRIED | | | 8. DIVORCED | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Japan | | | Permanent resident | | | WIDOWED | | | NEVER MARRIED | | | DIVORCED | | | Montgomery MD | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Sil. Spg. | | | Sil. Spg. Ave. | | | | | | | | | Homemaker | | | own home | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13. STREET ADDRESS | | | 20910 | | |
| Md | | | Mont. | | | Sil. Spg | | | YES | | | No | | | 20910 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | |
| Bunkichi | | | Miki | | | Kai | | | N/A | | | 559-27-4290 | | | Penny Carey-daughter-(same as 13e) | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a | | | | | | | | | | | | | | | | | |
| None | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | 20. AUTOPSY? | | |
| None | | | | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | TITLE (SPECIFY) | | | DATE SIGNED | | | | | | | | | | | |
| John S. Rogers, DME | | | M.D. Dep | | | Dec 28 1984 | | | | | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | | ADDRESS | | | 1919 Seminary Rd. Silver Spring, Md. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION
CITY COUNTY STATE | | | | | | | | |
| Cremation | | | 12-29-1984 | | | Lee's Cremator | | | Washington, D.C. | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| Hines/Rinaldi Funeral Home Sil. Spr. Md. | | | 11800 N.H. Ave., | | | JAN 3 1985 | | | Julia Davidson-Randall | | | | | | | | |



[Faint, illegible handwriting on lined paper, possibly bleed-through from the reverse side.]

14311 NO 10

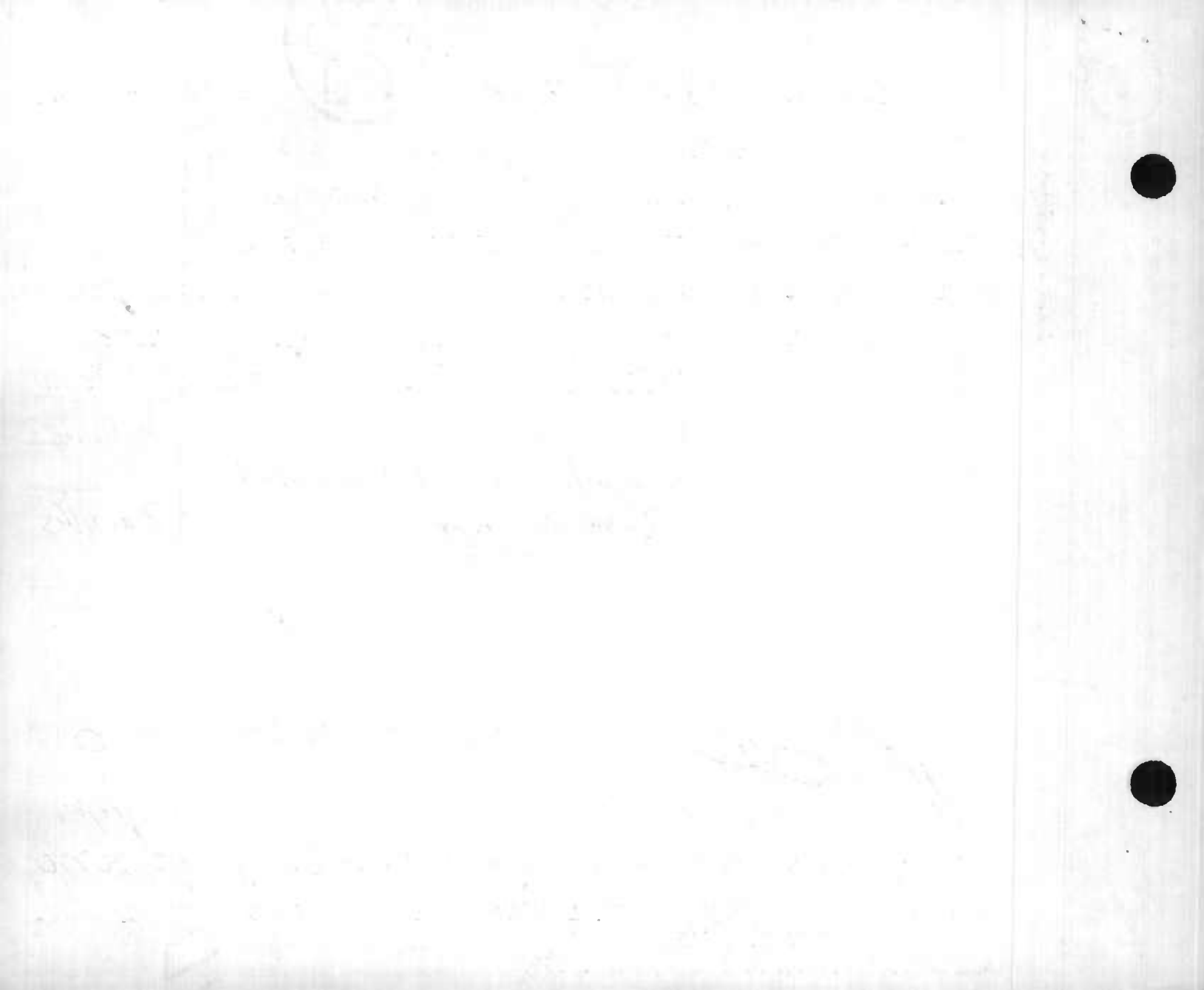
TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 34251
REG. NO. | |
|---|--|---|--|---|---|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ELEANOR GERALDINE YOUNT | | | | | 2a. DATE OF DEATH
MONTH 12 DAY 18 YEAR 84 | | | 2b. HOUR
0006 am | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH 1 DAY 29 YEAR 38 | | 6. AGE (IN YEARS LAST BIRTHDAY)
52 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
WASH. D C | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
XXXX TAKOMA PARK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
WASHINGTON ADVENTIST HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2920 CHAPEL VIEW DRIVE 20904 | | |
| 14. FATHER'S NAME
FIRST WILLIAM MIDDLE T. LAST READ | | | | | 15. MOTHER'S MAIDEN NAME
FIRST DOROTHY MIDDLE C. LAST MILLSTEAD | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
578-38-7281 | | 17. INFORMANT
CHARLES M. YOUNT | | | 17a. ADDRESS
SAME AS 13 | | 17b. RELATIONSHIP
HUSBAND | |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Perforated bowel
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic poorly differentiated
DUE TO, OR AS A CONSEQUENCE OF (c) adenocarcinoma
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
18 hours
2 months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 15 Nov 84 to 10 Dec 84 , that (1) (we) lost 19 Dec 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | | | | | |
| 22b. SIGNATURE
Thomas A. Bensinger MD | | | | | DEGREE
MD | | | 22c. DATE SIGNED
12/19/84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
THOMAS A. BENNINGER | | | | | 22e. ADDRESS
7525 Greenway Ctr Drive Greenbelt MD 20770 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
12/21/84 | | 23c. NAME OF CEMETERY OR CREMATORY
FT. LINCOLN CEMETERY | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BRENTWOOD PRT. GEORGE MD | | | |
| 24. FUNERAL DIRECTOR
NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | 25. DATE RECEIVED BY REGISTRAR
DEC 19 1984 | | | | | | |

BP



12+1

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR
1- STATE
REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 3 4 2 5 2 | | | | | | | | | |
|---|--|-----------------|----------------------|---|--|---|--|--|---|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Henry W. Zielinski | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED
MONTH DAY YEAR
12 21 84 | | | | | 2b. HOUR
1440 | | | | | | | | | |
| 3. SEX
M | | 4. RACE
CAUC | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 14 08 | | 6. AGE (IN YEARS)
LAST BIRTHDAY
76 YRS. | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
12 21 84 | | | 2d. HOUR
1440 | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Mass. | | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONT GOMERY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hospital | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Dept. of Parks | | | | |
| 13a. STATE
MD | | | 13b. COUNTY
MONT. | | | 13c. CITY OR TOWN
GAITHERSBURG | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS
18237 Lost Knife Cir | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Zielinski | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Joanna Bayer | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes | | | | | 16b. SOCIAL SECURITY NO.
WW11 378-24-8128 | | | | | 17. INFORMANT
Joyce Kisner | | | | | 12404 Village Sq. Terrace
Gaith. Md. 20852 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last
(b) CORONARY ARTERIOSCLEROSIS
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ACUTE
5 YRS | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | 21b. TIME OF INJURY
HOUR AM MONTH DAY YEAR
2 P.M. 12 21 19 84 | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
COLLAPSED ON FLOOR | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK AT WORK | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
HOME | | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
18237 Lost Knife C. GAITHERSBURG MONT MD | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Francis C. Mayle | | | | | TITLE (SPECIFY)
M.D. SEPT | | | | | MEDICAL EXAMINER
DATE SIGNED 12/22/84 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Francis C. Mayle | | | | | ADDRESS
8200 W. GAITHERSBURG AVE. BETHESDA MD | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | | 23b. DATE
12-23-84 | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Memorial Park | | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville Montgomery Md. | | | | |
| 24. FUNERAL DIRECTOR
NAME
Tyson Wheeler Funeral Home | | | | | ADDRESS
1331 Rockville Pike
Rockville, Md. 20852 | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 28 1984 | | | | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | |

BP

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(VR A15 ME (5))
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IN CASE 3 14 08 4

MENT COMPANY

NOTED

19 37 00 14 14

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578-24-8128

NOTED

NOTED

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NOTED

NOTED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH 10 DAY 17 YEAR 12 | | 2a. DATE OF DEATH
MONTH 12 DAY 12 YEAR 84 | | 2b. HOUR
5:08 PM | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
MARTZ EDWARD ZIMMERMAN | | | | | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS. | | | 7b. HOUR
5:08 PM | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Farmer | | | 12b. KIND OF BUSINESS OR INDUSTRY
Farming | | |
| 13a. STATE
Maryland | | | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Mt. Airy | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST George MIDDLE Melvin LAST Zimmerman | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST Daisy MIDDLE Martz LAST | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
218-30-4112 | | 17. INFORMANT
Patsy Z. Reece, | | | | ADDRESS
Item 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>irreversible cardiopulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>pulmonary embolism</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION
11-7-84, 11-12-84
12-12-84 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Fournier's gangrene | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/6/84</u> , 19 <u>84</u> , to <u>12/12/84</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>12/12/84</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Arthur F. Woodward Jr.</u> MD | | | | | | DEGREE
MD | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Arthur F. Woodward, Jr., M.D. | | | | | | 22e. ADDRESS
18111 Prince Philip Dr., Olney, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec. 15, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Olivet | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Frederick, Frederick Md. | | | | | |
| 24. FUNERAL DIRECTOR
Oran L. Molesworth, P.A., Damascus, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 17 1984 | | | | | |

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120719 III

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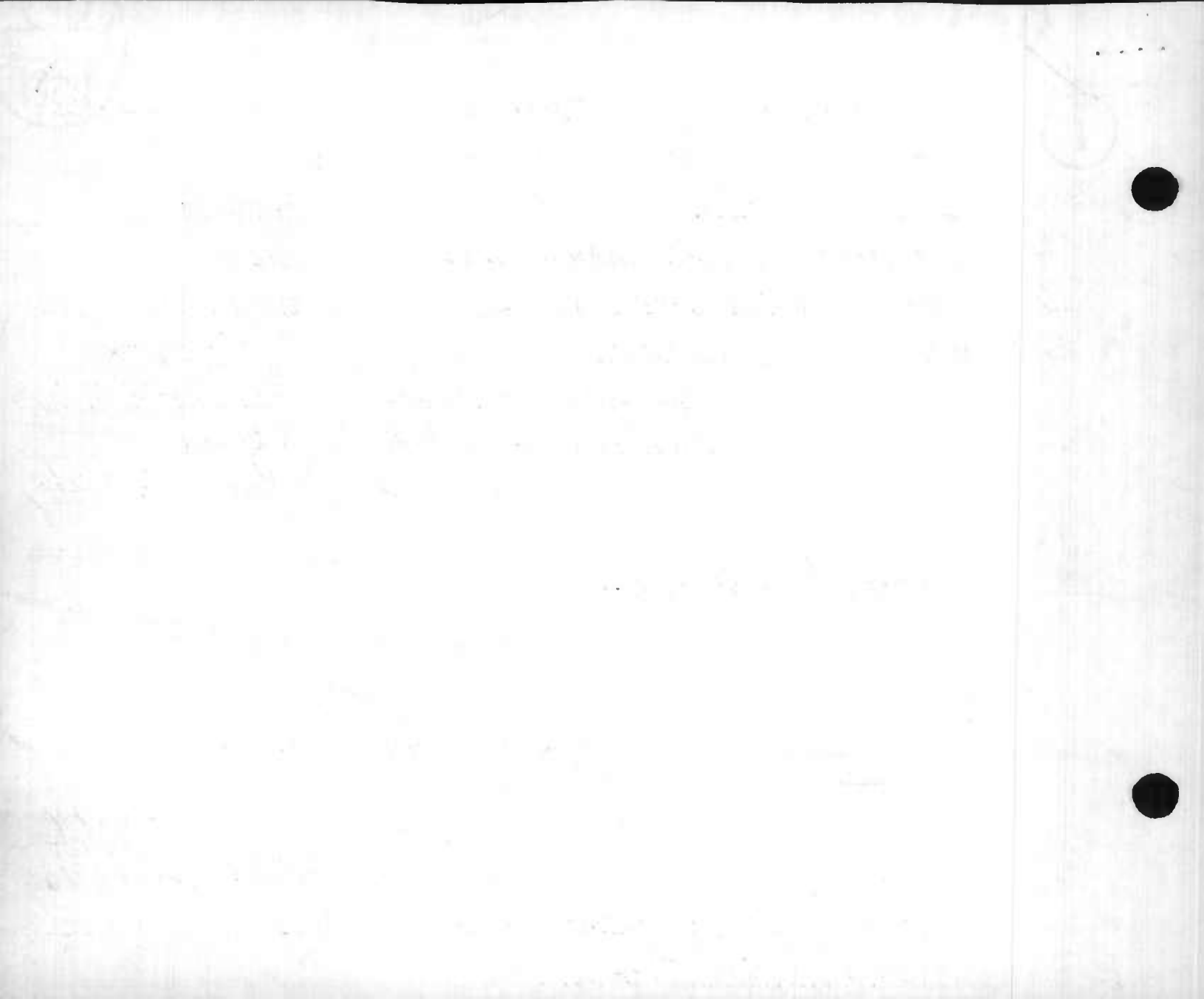
CHIEF

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 34254
REG. NO. | |
|--|--|---|--|---|---|--|--|--|--|-------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) SELMA ZINS | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 10 84 | | | 2b. HOUR
5:20 AM | | | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
OCT 3, 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
GERMANY | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SYLVAN MANOR N.H. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3 DELFORD AVENUE 20904 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
KARL SCHWANTHALER | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
JENNY LOEWENTHAL | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
052-24-2114A | | 17. INFORMANT
DAUGHTER | | ADDRESS
2301 GLENNALLEN AVE.
SILVER SPRING, MD. 20906 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Valvular + arteriosclerotic heart disease
DUE TO, OR AS A CONSEQUENCE OF (b) congestive failure
DUE TO, OR AS A CONSEQUENCE OF (c) 2 weeks | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
coronal arteriosclerosis | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (we) attended the deceased from April , 19 64 , to 12. 10 , 19 84 , that (I) (we) last saw the deceased alive on 12-7 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Jason Belger, M.D. | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12.10.84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JASON BELGER, M.D. | | | 22e. ADDRESS
8830 CAMDEN STREET
SILVER SPRING, MD. 20910 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
CREMATION | | | 23b. DATE
12/11/84 | | 23c. NAME OF CEMETERY OR CREMATORY
METROPOLITAN CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ALEXANDRIA VIRGINIA | | | | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS | | | | | | 25a. DATE RECEIVED BY REGISTRAR
DEC 13 1984 | | | | | |
| ADDRESS
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

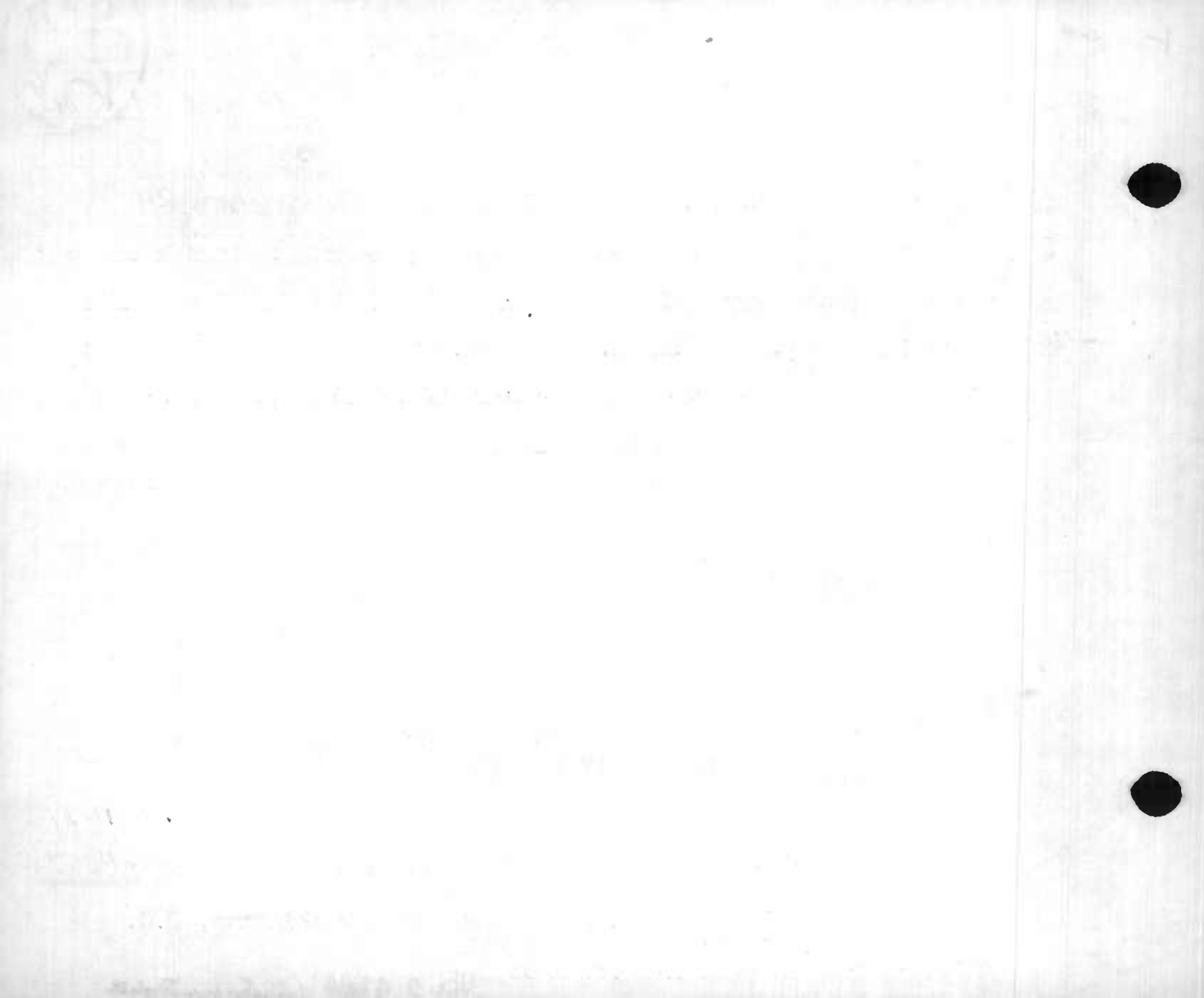
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

34255
REG. NO.

| | | | | | |
|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | HOUR MIN. | |
| IDA ZISLEN | | 12 19 84 | | 12:17 P.M. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YEAR | |
| Female | White | MONTH DAY YEAR | 93 YRS. | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Russia | U.S.A. | | MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | |
| Bethesda | Suburban Hospital | | Ret. Co-Business Owner Grocery Business | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | |
| Maryland | Montgomery | Bethesda | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 7004 Kenhill Road (20817) | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | |
| FIRST MIDDLE LAST | | | FIRST MIDDLE LAST | | |
| Moishe Mayer Silbert | | | Devorah (Unknown) | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | 577-42-5342 | | 20817 Arthur Sislen: 7004 Kenhill Rd.; Bethesda, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST | | | | | 5 minutes |
| DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia | | | | | 2 weeks |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: ASCUR | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from 12/14, 1984, to 12/17, 1984, that (2) (he) (she) last saw the deceased alive on 12/17, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.) | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| RAYMOND BASS | | MD ATTENDING PHYSICIAN | | 12-17-84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| RAYMOND BASS | | 3929 Ferrara Rd Wheaton Md 20906 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 12/19/84 | | D.C. Lodge Cemetery | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | |
| DANZANSKY-GOLDBERG MEMORIAL CHAPELS | | 1170 Rockville Pike; Rockville, Md. 20852 | | 25b. REGISTRAR'S SIGNATURE | |
| | | | | DEC 24 1984 | |

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

34256

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ANDREW JOSEPH ZSELTVAY, JR. | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 17 1984 | | 2b. HOUR
6:00 P.M. | |
| 3. SEX
MALE | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH DAY YEAR
DECEMBER 15 1927 | | 6. AGE (IN YEARS LAST BIRTHDAY)
57 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY
U. S. NAVY |
| 13a. STATE
MARYLAND | | 13b. COUNTY
ANNE ARUNDEL | 13c. CITY OR TOWN
SHADY SIDE | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ANDREW JOSEPH ZSELTVAY | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARGARET ELIZABETH LAZARY | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
1945-1977 | | 17. INFORMANT
MARGARET E. ZSELTVAY, 1308 W. RIVER ROAD, | |

11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **RESPIRATORY ARREST**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) **HEPATIC FAILURE**

DUE TO, OR AS A CONSEQUENCE OF

(c) **SMALL CELL LUNG CANCER**PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **SHADYSIDE, MD 20764**

MEDICAL CERTIFICATION

| | | | |
|--|---|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |

22a. I certify that (I) (this hospital) attended the deceased from **DECEMBER 7**, 19 **84**, to **DECEMBER 17**, 19 **84**, that (I) (we) lost saw the deceased alive on **DECEMBER 17**, 19 **84**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | |
|---|----------------------|---|
| 22b. SIGNATURE
<i>R. L. Nemecek</i> | DEGREE
(M) | 22c. DATE SIGNED
18 Dec 84 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
R. L. NEMEC, LT, MC, USNR | | 22e. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND,
NATIONAL CAPITAL REGION, BETHESDA, MD 20814 |

| | | | |
|---|------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
12/20/84 | 23c. NAME OF CEMETERY OR CREMATORY
Our Lady of Sorrows | 23d. LOCATION
CITY OR TOWN COUNTY STATE
West River, Md |
|---|------------------------------|--|---|

| | | |
|--|---|--|
| 24. FUNERAL DIRECTOR
NAME
Hardesty Funeral Home | 25a. DATE REC'D. BY REGISTRAR
DEC 18 1984 | 25b. REGISTRAR'S SIGNATURE
<i>Jana Davidson</i> |
|--|---|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

